Peer-to-peer reviews policy for medical authorizations

What's a peer-to-peer review?
A peer-to-peer review (P2P) is a discussion between a Priority Health Medical Director or Physician Reviewer and a member's treating physician following a medical authorization denial. The purpose of a P2P is to discuss the clinical information submitted with the initial authorization request.

This process allows providers to have regular, direct access to Priority Health Medical Directors or Physician Reviewers to discuss authorization denials.

Priority Health's Chief Medical Officer, VP of Medical and Clinical Operations, Medical Directors or Physician Reviewers may determine medical necessity for cases that don't meet medical criteria. We require clinical data to support medical necessity before authorizing days / services.

When is a P2P available?
Providers may request a P2P for any authorization request denied in accordance with National Committee for Quality Assurance (NCQA) utilization management standards, during the following timelines:

Request type	P2P request timeline
Pre-service requests	Within **15 calendar days** from the date of the denial notification
Inpatient urgent / emergent admission or long-term acute care hospital requests (commercial and individual)	Within **5 calendar days** from the date of the denial notification
Inpatient urgent / emergent admission or long-term acute care hospital requests (Medicare and Medicaid)	Offered as an intent-to-deny P2P for a short window **prior to** a denial being issued
Post-acute skilled nursing facility or acute / sub-acute rehab requests	Within **5 calendar days** from the date of the denial notification

When is a P2P not available?
A P2P isn't available to discuss administrative denial reasons including but not limited to non-covered services, benefit exceptions, ineligible members, readmissions or disputes regarding CMS 4201-F as published in the Federal Register (i.e., Two Midnight Rule).

Additionally, P2P requests aren't permitted:

- If a member or provider appeal has been submitted
- For retrospective authorizations, when the authorization request is submitted after the member was discharged

How can providers request a P2P?
For inpatient urgent / emergent Medicare and Medicaid authorizations where an intent-to-deny notice has been issued and it's within the allotted window prior to the issuance of denial, providers should call the designated number: 616.464.8246.

For commercial and individual members, every provider authorization denial notice includes information on how to request a P2P. If a provider requests a P2P, we'll call them to get it scheduled.

If the provider is unavailable at the scheduled call time / misses the P2P call, they may submit a medical necessity appeal. P2P call lines don't have a call-back feature.

Updates

Date	Update made
Nov. 2024	Removed section titled "What information is considered at a P2P?"
July 2025	Deleted: *For Medicare pre-service denials – Medicare doesn't allow reversal of adverse determinations via peer-to-peer review discussions for pre-service denials. Providers will need to request an appeal* • This statement was removed as P2P reviews are now allowed for and may overturn Medicare pre-service denials.
Dec. 2025	Updated to reflect the process for inpatient urgent / emergent P2Ps for Medicare and Medicaid authorizations that will be effective on Jan. 1, 2026