Peer-to-peer conversations for Medicare Advantage plans

Before a final adverse determination is made, a conversation between the physician ordering the services and the reviewing Medical Director is offered. These peer-to-peer (P2P) conversations are intended to provide an opportunity to discuss the services being requested for the patient and the clinical rationale for this treatment. P2P communication between the physicians helps to paint a more complete medical record and gives the best chance for the right decision to be made.

- For Medicare Advantage (MA) plans, discussion must be completed prior to the adverse determination being rendered.

- Once an adverse determination has been made for urgent, concurrent and retrospective cases, participating providers are able to submit a dispute under the following circumstances:

  - ✓ A physician/provider is contracted with Humana

  - ✓ Humana's adverse decision was based on evidence provided/supported at the time of the request

Providers have five calendar days from notification of the denied authorization to request the preclaim dispute.

Please refer to the Claims Dispute Process as shown on page 22 of Humana's Provider Manual for additional information.

Did you know?

Most Humana denials result from incomplete information about the specific requested service and/or missing clinical information.

Peer-to-peer conversations help ensure that a patient receives appropriate and medically necessary services. But there are also provider benefits, including multidisciplinary collaboration, enhanced quality of care and reduced risk.

The peer-to-peer process is designed to be scheduled prior to, or at the time an adverse determination is rendered.

Frequently asked questions

What is a peer-to-peer conversation?
A peer-to-peer (P2P) conversation is a telephone conversation between a board-certified, licensed Humana physician (Medical Director) and the physician or other healthcare professional requesting authorization for coverage. A P2P conversation is not specialty-matched.

What is the peer-to-peer process?
Prior to or at the time an adverse determination is communicated, the provider ordering services may be given an opportunity to discuss the services being requested for the patient and the clinical basis for treatment with a medical director through a peer-to-peer conversation.

Who is a Humana Medical Director?
A Humana Medical Director is a board-certified, licensed physician, versed in regulatory compliance, Centers for Medicare & Medicaid Services (CMS) policies, the National Committee for Quality Assurance (NCQA) guidelines, clinical reference materials and other sources of expertise.

How are authorization determinations made?
Humana uses a variety of guidelines in making utilization management determinations, including CMS NCDs (National Coverage Determination), LCDs (Local Coverage Determination), and Medicare Manuals; MCG* Care guidelines and Humana Medical Coverage policies (limited to approvals only). The guideline that is used is dependent upon the service requested.

Will Humana provide the specific criterion used to make the denial decision?
The denial notification will include the specific reasons for the denial. Providers may also obtain the guidelines used to make a specific adverse determination by contacting Humana.

Does Humana send a denial notification to both the patient and the provider?
Yes. A denial notification is sent to the patient or the patient's authorized representative every time Humana denies a service. The requesting provider and primary care physician are also copied. The denial notification contains the specific service that is being denied and the specific reasons for the denial.

Who can overturn a denial on appeal?
Humana medical directors and designated utilization management clinicians

How long does the appeal process take?
An appeal may take up to 30 days to process for Medicare Advantage cases. If you need us to expedite the grievance or appeal process, call us at **800-444-9137 (TTY: 711)**. Providers may find the reconsideration processes in the provider manual for physicians, hospitals and healthcare providers.

How do I request a retrospective review?
A request for retrospective review (after medical services have been provided and for which approval has not already been given) can be made by contacting the medical management department at **855-852-7005** and following the appropriate menu prompts, or by faxing the request to **888-527-0016**. Clinical information supporting the service must accompany the request.

What is Availity Essentials?
The Availity Essentials Portal is a multi-payer site where you can use a single user ID and password to work with Humana and other participating payers online. Availity Essentials is compliant with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, and there is no cost to register.

For select services on Humana's preauthorization list, providers now have the option to use preauthorization automation (automated data exchange between provider and payer) on the Availity Essentials Portal to get faster approvals by answering a few clinical questions.

I often submit my preauthorization requests on my practice management system or phone. Is the Preauthorization Automation Tool available for those request methods?
No. The tool is available only on the Availity Essentials Portal at this time.

- If you are not registered for the Availity Essentials Portal, please register here so you have access to the most up-to-date resources and tools
- As reference, here is a printable handout with Availity Essentials registration instructions.
- If you have the electronic funds transfer (EFT) information from a Humana check, you can register and start using Availity right away.

Who can I contact if I have questions about online tools on the Availity Essentials Portal?
If you have problems using the Availity Essentials Portal, call Availity Essentials Client Services at **800-AVAILITY (800-282-4548)**. Assistance is available Monday – Friday, 8 a.m. – 8 p.m., Eastern time, excluding holidays.

*MCG Health is part of the Hearst Health network.