Neighborhood's Peer-to-Peer Review Process and Phone Line

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In an effort to facilitate medically necessary care for Neighborhood members, Neighborhood will afford the provider of record a reasonable opportunity to discuss a denied member request with a physician during a peer-to-peer discussion. This opportunity to discuss denial decisions is not considered to be an initiation and/or part of an appeal. Providers should follow the procedure below (also in Neighborhood's **Provider Manual**) and note that peer-to-peer review is only available for Neighborhood Medicaid and Commercial/Exchange members (INTEGRITY is excluded from the peer-to-peer process).

1. The requesting provider has five (5) business days from receipt of the denial notification (verbal, fax, or letter notification) to schedule a peer-to-peer review by calling 1-401-459-6608. Peer-to-peer reviews can also be initiated by Neighborhood Associate Medical Director (AMD) staff to the requesting provider.
    - If the peer-to-peer request is made more than five (5) business days after the denial notification, or the member has been discharged from inpatient hospitalization, then the requesting provider will be instructed to file an appeal on behalf of the member.
    - The appealing provider should specify the area of appeal. For example, if the issue is a specific date of service, the date of service should be specified in the appeal. Once an appeal is formally requested and filed, any notes from the peer-to-peer discussion will be reviewed during the appeal process.
2. The AMD will respond to requests for peer-to-peer reviews with the requesting provider within one (1) business day of the request to obtain clarification, additional clinical information, and/or other pertinent information to render a final medical determination.
3. If the AMD requests additional information during a peer-to-peer discussion, the additional information must be submitted within two (2) business days of the discussion in order to be considered during the peer-to-peer discussion process. If the information is received after this timeframe, the initial decision will be upheld.
4. The peer-to-peer review will include, at a minimum, the clinical basis for the Neighborhood decision and a review of documentation or supporting clinical information, if any, that can be submitted that may lead to a different utilization review decision.
5. A peer-to-peer review will not be scheduled if a formal member appeal has already been filed. Peer-to-peer review discussions are for medical necessity denials rather than administrative denials. Administrative denials must be appealed through the appeal process.
6. Once a final decision is rendered, it will be recorded in the Neighborhood clinical system and notification of the determination (if changed), will be communicational to the member and provider per regulatory guidelines.

Providers and members continue to have appeals rights based on any final adverse determination after the peer-to-peer process. In the event of a denial under peer-to-peer review, the Medical Director will discuss with the provider the reason for the denial, and an explanation of the appeals process.

In an effort to address clinical concerns in a timely fashion, Neighborhood asks that providers restrict use of peer-to-peer line for review requests only. Neighborhood's Providers Services department can assist with all other inquiries or issues and can be reached by calling 1-800-963-1001. Call center staff is available Monday through Friday, from 8:00am to 6:00p.m.