Magellan Healthcare's Peer-to-Peer Process

What to expect when calling in for a peer-to-peer discussion:

- A peer-to-peer discussion may be initiated at any time during the prior-authorization process by calling the Magellan Healthcare Call Center.
- A peer-to-peer discussion may not be necessary if the requested clinical documentation is sent prior to contacting Magellan Healthcare.
- A peer-to-peer may be initiated by the office staff (non-clinical), but the case discussion must be conducted by a licensed clinician from the provider's office.
- Plan to call a few minutes prior to licensed clinician's availability to provide necessary case information.
- Identifying member information will need to be provided before the call is transferred to an appropriate clinical reviewer that is specific to the case and modality (for RBM/Cardiac/IPM).
- If the office needs to schedule the peer-to-peer discussion, at least two convenient callback times will need to be provided to accommodate the licensed clinician's schedule (for Physical Medicine/MSK).
- The case will then be discussed, including any additional information that may be necessary for the case to meet medical necessity. *
- Verbal clarification of clinical information from the medical records that were submitted may be discussed during the peer-to-peer. Examples include clarification of conflicting information in the notes or typographical errors.
- Any new information necessary to approve the request must be submitted in writing by uploading to RadMD.com or faxing to 1-800-784-6864 before a new determination can be made. *
- If the case cannot be approved at the time of the peer-to-peer; the ordering/rendering provider is asked to follow the appeal instructions provided within the denial notification.

If you would like to provide feedback regarding a peer-to-peer discussion, please contact your Magellan Healthcare dedicated Provider Relations Manager.

* This discussion may be for consultation purposes only if the re-review/reconsideration/re-open timeframe has expired or the case has a final determination and re-review/reconsideration/re-open is not available. If re-review/reconsideration/re-open is not available, providers must follow appeal instructions in the denial notification. Please confirm with the health plan if re-review/reconsideration/re-open is available.