Clover Health

Policy Title	UM-004 Peer-to-Peer Review
Policy Department	Utilization Management
Effective Date	6/16/2026
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Disclaimer:

Clover Utilization Management applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Purpose: This Policy and Procedure (P&P) establishes Clover Health's ("Clover") policy and procedure for Peer-to-Peer (P2P) Review.

Scope: This Policy and Procedure applies to Medical Director (MD) discussions with the provider community.

Policy: Clover's Medical Directors may discuss health plan operations, clinical decision making, and care management with the community.

Clover Health

Procedure

● Hospital Admission P2P

○ Prior to or after rendering a decision, the Medical Director may (ie psychiatric cases, Out of Network Hospitalizations) contact the provider to discuss clinical issues or care management needs

○ Once the NDCS has been issued, the Contracted Provider may initiate a P2P review with Clover's Medical Director by calling Clover's Customer Service telephone number or after an oral notification was provided while the member is still admitted to the hospital. Exceptions will be granted on a case by case basis for Clover decisions provided after the member was discharged.

○ Adverse determinations for Out of Network providers may not be reversed (overturned) by a Peer-to-Peer discussion if conducted after the denial has been finalized except under certain circumstances (see UM-016 Reopenings for Organization Determinations)

○ In Network P2P requests will not be honored until clinical information about the admission has been provided to clover

● Post-Acute p2p Notice of Medicare Non-Coverage (NOMNC) Terminations

○ May be initiated as necessary by the Clover Medical Director

○ May be initiated after a NOMNC has been issued only if there is a change in the member’s medical condition after the NOMNC has been issued and given the member is still in the facility..

○ To be eligible for the P2P, Clover must have received a copy of the signed NOMNC prior to P2P scheduling.

○ If there is no change in the member’s medical condition after a NOMNC is issued, the appeal is to be filed with the Quality Improvement Organization (QIO) if done prior to noon in the service area on the day before the LCD or with Clover’s Appeals team if the cut off time for the QIO appeal is missed.

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- How do providers schedule a peer to peer:

  - Intake and scheduling of P2P requests are processed through the UM Service Task System or during the time of oral notification.

Definitions:

1. Adverse Organization Determination means that the Plan denies authorization or payment for services based on established, evidence based clinical review criteria. Denials may be based on fully or partially denied prospective (pre-service, i.e., requests from a practitioner or member before services are delivered) concurrent (i.e., review of services currently being provided in a clinical setting), or retrospective (post service, i.e., submission of a request for authorization or payment after services are delivered).

2. Notice of Medicare Non-Coverage (NOMNC) - The NOMNC is to be used for termination of ongoing Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), and Home Health Agency (HHA) services.

3. Notice of Denial of Coverage for Services (NDCS) - The NDCS is issued to contracted providers for adverse determinations, in whole or in part, of post-service and unplanned admissions in which the member is held harmless and not financially liable above their obligated copays and deductibles per their contract with Clover.

4. Beneficiary Family Centered Care - Quality Improvement Organization (BFCC-QIO or QIO) is a group of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare. Livanta and KePro are the two QIOs designated by CMS to process and review appeals for services.

References
Medicare Managed Care Manual