Clover Health

Policy Title	UM-030 Concurrent Review
Policy Department	Utilization Management
Effective Date	06/116/2026
Revision Date(s)	6/4/24, 5/27/25, 5/26/26

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 concurrent review.

Scope:

This policy and procedure applies to all medical necessity reviews conducted by Clover while the member is receiving care during an inpatient admission.

Policy:

Clover Health conducts concurrent review for inpatient services, including but not limited to, admissions to psychiatric units or hospitals, inpatient rehab facilities (IRF), long term care hospitals (LTCH) and skilled nursing facilities (SNF).

Clover will request clinical updates throughout the duration of the member's stay to ensure services are medically necessary. Upon discontinuation of previously approved inpatient

services, hospitals and SNFs will receive written notification in the form of an IDN or NOMNC, respectively, as well as verbal notice via phone.

Treating facilities are required to ensure CMS guidelines are met for admission throughout the member's stay. Clover will honor requests for a peer-to-peer (P2P) if requested by the hospital prior to discontinuation of coverage for a previously approved stay. Upon denial, hospitals must issue the Important Message from Medicare (IM) to the member to ensure the appropriate appeal rights and instructions are given to the member. If the attending physician does not issue a discharge order after Clover issues a denial letter the member or hospital may file an appeal or payment dispute post-discharge. An appeal may be submitted to the QIO while the member is still admitted only after the IM is issued.

Skilled nursing facilities are required to provide the member with a copy of the NOMNC the same day the NOMNC is issued to ensure the member is informed of their appeal rights timely. A P2P may be allowed for a discontinued SNF stay if the member experiences a change in condition after the NOMNC is issued. The SNF must request the P2P prior to the last covered date on the NOMNC and must send the signed NOMNC back to Clover before the P2P is scheduled. Clover will not accept a P2P request unless a signed NOMNC is on file and/or documentation is provided to state the member's condition has changed and the member continues to need SNF level of services, after the NOMNC was issued.

Procedure:

1. **Auth submission and initial determination**
    a. Providers must submit a prior authorization request for all non-emergent inpatient hospital services and post-acute admissions prior to admitting the member.
    b. Clover will review the request for medical necessity and render a determination.
        i. If approved, the member may be transferred to the PAC facility
        ii. If not approved, the member may file an appeal, request prior authorization for a lower level of care (if applicable) or be discharged home.
2. **Concurrent review**
    a. Once the member is admitted, Clover may ask for regular clinical updates throughout the member's stay.

b. Providers must submit clinicals for review no later than the member's last approved day to ensure no lapse in coverage.
    i. In addition to submitting updated clinical for review, providers may also request a P2P.
    ii. Requests for a P2P must be made prior to the last approved date.
    iii. P2P requests made after a denial is issued may not be honored.
        1. If the Clover MD and hospital MD agree the member is safe for discharge Clover will proceed with discontinuing coverage for the current stay and a denial letter will be faxed to the facility. Clover will also call the admitting facility to notify the appropriate staff coverage for the stay has been discontinued.
        2. If the Clover MD and hospital MD agree the member is not safe for discharge, the Clover MD will extend the authorization for coverage of additional days and require that medical records are submitted at a later date for concurrent review.
        3. In the event that agreement is not reached by both parties Clover may proceed with discontinuing coverage for the stay while the member remains in the facility. Hospitals may submit a post-discharge appeal for payment of services that were not approved by Utilization Management after the related claim is processed.
c. A medical necessity review will be completed to ensure the member's condition warrants continued stay in the inpatient setting.
    i. If the member meets CMS criteria for continued stay and provision of services, the approval date range will be extended and the facility will be notified coverage for the stay has been extended via phone or fax
    ii. If the member no longer meets CMS criteria for continued stay in a skilled nursing facility or transitional care unit, Clover will issue a NOMNC upon discontinuation of coverage for the stay. The NOMNC must be issued to the member, by the admitting facility, the same day the NOMNC is issued to ensure the member receives their appeal rights timely.
    iii. If the member no longer meets CMS criteria for continued stay in a long term care hospital, inpatient rehabilitation facility or inpatient Psychiatric facility or Psychiatric unit, Clover will issue the IDN which includes the denial rationale.

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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. **Concurrent Review** is the review of medical necessity for member care throughout the cycle of medical services provided.

3. **Important message from Medicare (IM)** is a CMS mandated notice that all Medicare participating hospitals are required to issue to the member upon admission and again at least two days prior to discharge.

4. **Integrated Denial Notice (IDN)** is a CMS mandated notice that Clover is required to issue when discontinuing previously authorized services.

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

6. **Peer to Peer (P2P)** is a consultation via phone between the plan physician and treating physician

7. **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.