Clover

Clover Health Itemized Bill Review Reimbursement Policy Policy #RP-006

Policy Title	Itemized Bill Review Reimbursement Policy
Policy Department	Payment Strategy and Operations
Effective Date	1/1/2022
Revision Date(s)	1/1/2022
Next Review Date	

Disclaimer:

Clover Health 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.

Description:

This policy outlines the process and procedure for itemized bill reviews for qualified inpatient claims.

Definitions:

- **Cost-Outlier**
  - Payment due, in addition to the DRG payment, that is based on the facility unique fixed-loss cost threshold amount
- **Inpatient Claim**
  - A facility claim billed with an inpatient place of service
- **Itemized Bill Review**
  - The process of reviewing the total billed amount of an inpatient claim for duplicative and/or excluded charges per CMS rules and regulations

Policy:

Clover Health has contracted with Optum Health Services to conduct itemized bill reviews for claims that generate outlier payments due to above average costs.

The Center for Medicare and Medicaid Services (CMS) reviews the accounting and costs associated with hospital stays for each facility, individually. Based on this review, facilities will have a fixed-loss cost threshold amount that is unique to that facility and the CMS cost report.

When an inpatient claim is submitted to Clover Health, and the costs are above the fixed-loss cost threshold amount, the claim may qualify for an additional cost outlier. Once identified as a cost outlier claim, Optum Health Services will send a letter to the provider requesting a copy of the itemized bill.

The purpose of the itemized bill review is to identify instances of unbundling, billing errors, incorrect charges/bill type, insufficient documentation, level of care inconsistencies, and to ensure all billed charges are appropriate. Once the review is completed, the provider will receive a letter from Optum detailing the findings.

If the review identifies inappropriate billed charges, Optum will notify the provider in writing and those billed charges will be removed from the claim for pricing purposes. The claim will be processed with the allowable amount that corresponds to the adjusted billed amount. If an itemized bill is requested and not received, the claim will process without the cost outlier included in the payment.

References
CMS Outlier Payments - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier
Outlier Cases - 42 CFR 412.80 through 412.86