Clover

Clover Health Postpay Review Reimbursement Policy Policy # RP-002

Policy Title	Postpay 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:

Clover Health is responsible for ensuring that all items and services provided to our members are properly reimbursed. In order to meet this requirement, Clover engages in a variety of post payment reviews of claims including coding reviews and medical record reviews.

Definitions:

- **Diagnosis Related Group (DRG)**
  - This is a three digit billing code used for inpatient acute care claims. Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.
- **Medicare Advantage Organization (MAO)**
  - A Medicare Part C plan, which is CMS approved to provide benefits to Medicare members
- **Coding Reviews**

    - Claim reviews that can review diagnosis codes and procedure codes for coding appropriateness, including Medically Unlikely Edits, NCD and LCD criteria
- **Medical Record Review**
    - Claim review that includes clinical validation that an item or service was properly billed and clinically necessary

Policy:

Clover is required by CMS to review medical records and claim coding for a number of reasons. For example, Clover must have effective programs to control waste, fraud and abuse as required by CMS. Under Plan fraud, waste and abuse obligations, in addition to other duties, Clover is responsible for:

- Reducing or eliminating Parts C and D benefit costs due to fraud waste and abuse;
- Ensuring proper value of Parts C and D benefits, including correct pricing, quantity, and quality;
- Reducing or eliminating fraudulent or abusive claims paid for with federal dollars.

To implement this requirement, Clover Health, like other MAOs, engages in post payment medical and coding review to ensure that the organization only pays for services that meet Medicare coverage criteria and/or are covered under the member's evidence of coverage.

Clover uses a variety of methods to meet this requirement, which can include:

- Coding software for procedure/diagnosis code validation
- Vendor reviews
- Pricing Validation
- Medically Unlikely Edits
- Overutilization of Services
- Centers for Medicare & Medicaid Services (CMS) guidelines using Medicare manuals
- Medicare Local Coverage Determinations and National Coverage Determinations
- Clover policies, including medical coverage policies, Clover provider manuals, claims payment policies
- National Uniform Billing Guidelines from the National Uniform Billing Committee
- Current Procedural Terminology (CPT) guidelines
- Healthcare Common Procedure Coding System (HCPCS) rules
- ICD-10-CM Official Guidelines for Coding and Reporting

- Industry-standard utilization management criteria and/or care guidelines, including MCG care guidelines and InterQual guidelines

Consistent with CMS guidance located in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, section 80.3, Clover has up to 4 years from the original organization determination to flag a claim for review with good cause.

If an overpayment is identified as a result of a post payment review, the provider will be notified via letter of the finding. If records are requested for a post payment review and are not received, the claim may be subject to a technical denial per CMS guidance.

Providers have a right to dispute review findings and can follow the guidance in the notification letter for that dispute process.

References
Medicare Program Integrity Reports Chapter 7
Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance