Policy Title	Denials and Terminations
Policy Department	Utilization Management
Effective Date	2/18/2023
Revision Date(s)	10/11/2017, 11/08/2019,7/13/20, 7/2/21, 2/18/22,2/18/23

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:

The purpose of this policy is to establish Clover Health's procedures on when and how to use the Integrated Denial Notice (IDN), Notice of Medicare Non-Coverage (NOMNC), Detailed Explanation of Non-Coverage (DENC), Notice of Denial of Coverage for Services (NDCS) and the Detailed Notice of Discharge (DND).

Scope:

This policy is to define how the denial and termination templates within the Utilization Management (UM) department are to be used. The execution of the templates in regards to timeliness and specific recipients are not within the scope of this policy.

Policy:

When rendering an adverse determination, in whole or in part, denials and terminations of services are to be finalized and delivered with the appropriate notices and verbiage to providers and members.

Procedure:

1. **Integrated Denial Notice (IDN)**
    a. The IDN will be issued for all adverse determinations, in whole or in part, of pre-service authorization requests.
    b. The IDN is to be used for continued stay cases where UM has decided services must stop.
        i. An IDN that is executed with the "Stopped" verbiage for denials of continued stays are only needed if there is an additional request for services beyond what was already approved.
            1. Examples: Long Term Acute Care Hospital stays, Inpatient Psychiatric stays, and Acute Rehabilitation stays.
            2. If there are no further requests for a continued stay after an approval determination, the case does not need to be closed out with a "Stopped" IDN.
    c. The IDN is to be used where previously approved services have been reduced upon further review.
        i. Example: A reduction is intended to mean the provision of a service that has already been approved is now being reduced. For example, 20 physical therapy visits have been approved but after the member has used 10 physical therapy visits, it is deemed no longer necessary.
    d. Clover will issue all denial decisions in a manner and format that is understandable to the member.
2. **Detailed Notice of Discharge (DND)**
    a. The DND is only necessary when a fast appeal, for a decision that inpatient hospital care is no longer necessary, has been filed with the BFCC-QIO.
3. **Notice of Medicare Non-Coverage (NOMNC)**
    a. 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.

i. A NOMNC would be used to terminate ongoing coverage of Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), and Home Health Agency (HHA) services.
ii. The Last Covered Date (LCD) on a NOMNC, Last Approved Date (LAD), is the last day of coverage. All days after the stated LCD are not covered.

4. **Detailed Explanation of Non-Coverage (DENC)**
   a. The DENC is only necessary when a fast appeal has been filed with the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO).
5. **Notice of Denial of Coverage for Services (NDCS)**
   a. 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.
6. **Policy and Practice Guideline Review Frequency**
   a. This Clover policy and procedure along with any Medical Management practice guidelines are reviewed annually and presented to the Chief Medical Officer, Medical Management Committee, and Quality Improvement Committee.

References
Medicare Managed Care Manual Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance