Clover

Clover Health Member Balance Billing Reimbursement Policy Policy # RP-028

Policy Title	Member Balance Billing Reimbursement Policy
Policy Department	Payment Strategy Operations
Effective Date	1/1/2022
Revision Date(s)	3/1/2022
Next Review Date	

Disclaimer:

Clover Health applies The Center for Medicare and Medicaid Services (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 describes the Center for Medicare and Medicaid Services (CMS) rules around member balance billing. When an item or service is non-covered, in certain situations, the member may be billed. If an item or service is denied by Clover Health, the provider may not balance bill the member.

Definitions:

- **Balance Billing**
  - Billing a member for items or services that are not payable by Clover Health
- **Medicare Participating Provider**
  - A Provider that signs an agreement with Medicare to always accept Medicare assignment.

Policy:

If you are a Medicare-participating provider or you contract with Clover Health, you cannot balance bill or inappropriately bill members. Any such billing is a violation of the Provider Agreement and applicable state laws and may result in CMS sanctions.

Providers who willfully or repeatedly balance bill members will be referred by Clover Health to the relevant regulatory agency for further action. Inappropriate member billing includes billing members for services where payment from Clover Health has not been obtained due to claim cleanliness or other billing issues.

A provider of services may only collect cost-sharing amounts from the member for covered items and services. A claim denial or a payment reduction does not constitute a non-covered item/service. If the item or service in question is generally covered by Clover Health, but the claim is denied due to a billing/coding issue or an authorization denial, the provider cannot balance bill the member the denied cost.

If the provider properly notifies the member, the provider may seek payment from the member. If Clover Health pays all or part of the items or services the member paid, the member must be refunded in a timely manner.

If the required notice is not issued or invalid, and the provider knew or should have known that the item or service is usually non-covered, the provider may be held financially liable and payment cannot be collected from the member.

CMS defines 3 conditions for categorization of member balance billing - only one of the below conditions can apply to a given service:

1. Services that are **Statutory Exclusions** - e.g. not a Clover benefit
    a. The member has potential liability for the item or service, if that item or service is always submitted as non-covered
2. A **reduction or termination in previously covered care** or a determination of coverage, which requires a notice of non-coverage
    a. If the service is covered, Clover Health would pay - if the service is not covered then the member may be liable if sufficient advanced notification was provided to the member
3. **Covered Services**
    a. Clover Health is liable unless it is denied as part of a determination on claim, in which case liability may rest with the provider. The member cannot be balance billed for a covered service, the member is only liable for copay or coinsurance

Out-of-Network Clover Providers

If a provider is participating with Medicare, they may not balance bill Clover members, as they

are still Medicare members. Medicare participating providers may never balance bill Clover members because they have agreed to always accept the Medicare allowed amount as payment in full.

The same criteria listed above would apply to providers that are out-of-network with Clover Health, but participate in Medicare.

Non-Medicare-Participating Provider
Clover Health will pay Medicare Non-Participating providers the difference between the member's copay and the original Medicare limiting charge (the maximum amount that Medicare requires Clover to reimburse a provider). The member only pays Clover cost sharing.

Claim Codes (if applicable)	**Modifiers** • **GY -** Report Medicare statutorily excludes the item or service, or the item or service doesn't meet the definition of a Medicare benefit. Use this modifier combined with modifier –GX. • **GZ -** Report when you expect Medicare to deny payment of the item or service because it's medically unnecessary and you didn't issue an ABN.

References
Summary of Fiscal Intermediary Billing of Non-Covered Charges
MLN Booklet - Items & Services Not Covered Under Medicare
Clover Health Provider Manual
MA Payment Guide for Out of Network Payments
Medicare Managed Care Manual - Chapter 4 - Benefits and Beneficiary Protections, Section 170
Medicare Advance Written Notices of Non-Coverage