Clover

Clover Health Hospice Coverage Reimbursement Policy

Policy # RP012

Policy Title	Hospice Coverage 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 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 explains the payment responsibilities of Clover Health when a member has elected hospice coverage with The Center for Medicare and Medicaid Services (CMS).

Definitions:

- **Medicare Advantage Prescription Drug System (MARx)**
  - A database maintained by CMS that provides member eligibility information
- **Hospice**
  - A comprehensive, holistic program of care and support for terminally ill patients and their families. Hospice care changes the focus to comfort care (palliative care) for pain relief and symptom management instead of care to cure the patient's illness

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Policy:

When a Clover Health member elects hospice, the provider of services should bill CMS directly for payment of claims for items and services covered by CMS. For any supplemental benefits, providers should bill Clover Health.

Members are permitted by CMS to go in and out of hospice coverage - it is important to determine if the member has elected hospice on the DOS or admission date for facility claims. Hospice can be elected at any date during the month, and from the election date forward, providers should bill CMS for payment.

If the member is disenrolled from hospice, providers should bill CMS for claims through the end of the disenrollment month - e.g. terminate hospice on 2/3/2021, CMS would pay all claims with a date of service (DOS) or inpatient admission through 2/28/2021.

For facility claims, if the member has elected hospice on or after the admission date, CMS is responsible for the entire length of stay (even if the member is disenrolled from hospice in the middle of the stay). If the member has disenrolled from hospice, and the member is later admitted into inpatient the same month as the hospice disenrollment, the facility should bill CMS for the entire admission.

References
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf Section 10.4 – Hospice Coverage (Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf Section 30.4
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