Clover

Clover Health Validation & Prepayment Review: New Non-Contracted Out of Network Providers

Policy # RP-082

Policy Title	Validation & Prepayment Review: New Non-Contracted Out of Network Providers Policy
Policy Department	SIU
Effective Date	12/1/2025
Revision Date(s)	
Next Review Date	12/1/2027

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:

Establishes strict protocols for the validation and prepayment review of all claims submitted by new non-contracted (Out-of-Network) providers. This policy ensures that reimbursement is issued only for valid, medically necessary services rendered by eligible providers in accordance with Centers for Medicare & Medicaid Services (CMS) regulations regarding Fraud, Waste, and Abuse (FWA).

Definitions:

- Non-Contracted (Out-of-Network) Provider: A healthcare professional, facility, or supplier that does not have a formal participation agreement or contract with Clover Health.
- Prepayment Review: A process where claims are identified for clinical or administrative review prior to payment to ensure the services were rendered as billed and meet medical necessity and reimbursement requirements.
- Request for Information (RFI) / Additional Documentation Request (ADR): A formal notice sent to a provider requesting specific medical records, invoices, and/or identity credentials required to adjudicate a claim.

Policy:

Policy

Clover Health is committed to the integrity of the Medicare Advantage program and the protection of federal funds through the prevention of Fraud, Waste, and Abuse (FWA). It is the policy of the Plan to subject claims from Non-Contracted (Out-of-Network) providers to comprehensive validation and Prepayment Review when such providers lack an established billing history and/or exhibit billing behaviors that deviate from CMS-recognized benchmarks. In accordance with 42 CFR § 422.503 and 42 CFR § 422.520, claims subject to this review will not be adjudicated for payment until the Plan has verified the legitimacy of the provider, the validity of the referring relationship, and the medical necessity of the services rendered. The Plan reserves the right to deny reimbursement in full for any claim that fails to meet the minimum validation criteria or for which the provider fails to submit requested substantiating documentation within the mandated operational timelines.

Clover reserves the right to place any non-contracted provider on 100% Prepayment Review if they meet one or more of the following triggers:

1. **New Provider Status:** No prior billing history with the Plan.
2. **Volume Spikes:** A sudden, significant increase in claim volume or total billed charges.
3. **High-Risk Coding:** Frequent use of high-severity codes (e.g., Level 5 E&M, high-cost DME, genetic testing) without established history.

Validation Criteria

Claims must pass the following validation checks. **Failure to meet any criteria will result in claim denial.**

1. Provider Identity & Legitimacy

- **NPI & Taxonomy:** NPI must be active and match the taxonomy code for the services billed.

- **Address Verification:** Billing address must be a verifiable physical location. Commercial mail drops, virtual mail boxes, non business properties, etc. will not be verified to bill Clover Health.
- **W-9 Attestation:** A current W-9 must be on file.
- **External Validation:** Clover will review the information submitted to ensure it is authentic, accurate and in line with Clover and CMS policies.
- **Laboratory (CLIA):** Requires a valid CLIA certificate (waiver, compliance, or accreditation) matching billed codes.
- **DMEPOS:** Requires a signed Written Order Prior to Delivery (WOPD), Proof of Delivery (POD), and proof of Accreditation.

2. Medicare Eligibility

Providers are screened against:

- CMS Opt-Out Affidavit List
- CMS Preclusion List
- OIG LEIE and GSA SAM debarment lists

3. Service & Referring Provider Verification

- **Medical Records:** Complete medical records are required to verify services were rendered and medically necessary.
- **Referring Provider:** Must have a valid NPI, be enrolled in PECOS, and not appear on exclusion lists.
- **SIU Interview:** The Plan may conduct verbal interviews with referring clinicians to validate signatures and referral relationships.
- **Member Verification:** The Plan may contact beneficiaries to verify receipt of services, provider recognition, and appointment dates.

Operational Timelines

Action	Timeline

Request for Information (RFI)	Issued upon receipt of claim.
Provider Response Deadline	45 calendar days from the request date.
Failure to Respond	Claim denial on Day 45.
Plan Adjudication Window	60 calendar days following receipt of complete documentation.

Note: The prompt payment clock stops on the date the RFI is generated and resumes only when all requested documentation is received.

Regulatory Authority	The Plan's authority to request additional information and conduct prepayment reviews is grounded in the following mandates: ● 42 CFR § 422.503(b)(4)(vi) ● 42 CFR § 422.520 ● Medicare Managed Care Manual, Ch. 21, § 50.7 ● 42 CFR § 422.220 & § 422.222