eviCore healthcare
Provider Manual

- ✓ Home Health Care Services
- ✓ Durable Medical Equipment
- ✓ Sleep PAP Therapy Device Management – TherapySupport℠
- ✓ Home Infusion Therapy
- ✓ Care Coordination Services

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Introduction

This eviCore healthcare (eviCore) Provider Manual describes critical requirements and pertinent program information for your organization as a participating provider in the eviCore healthcare Network. All current policies and procedures associated with this manual can be located online at www.eviCore.com. eviCore reserves the right to change the provisions of this manual at its sole discretion and will provide notice of such changes via email and/or through updates to the online version of the manual housed at www.eviCore.com. Notifications of periodic updates and program modifications will be posted on this website for your attention. eviCore also utilizes emails to communicate program updates and changes. Lastly, eviCore can use contact emails gained from training documentation to deliver notice when updates are made. You are encouraged to visit our website regularly to keep abreast of important information on protocol and policy changes, administrative information, and clinical resources.

The information in this manual details your rights and responsibilities as an eviCore Participating Network Provider (PNP). It also provides detailed information about your contractual responsibilities, performance guarantees, regulatory obligations, and recommended eviCore protocols. As indicated in your Provider Agreement, you are obligated to comply with all terms listed in the eviCore Provider Manual.

Topics contained in the Provider Manual include but are not limited to

- Operational Standards and Requirements
- Utilization Management
- Portal Capabilities and Support
- Provider Complaints
- Post-Denial Determinations, Appeals, and Reconsiderations
- Program Descriptions:
    - Care Coordination Services
    - Home Infusion Therapy
    - Home Health Care Services
    - Durable Medical Equipment
    - Sleep PAP Therapy Device Management – TherapySupport
- Provider Performance Levels and Metrics

www.evicore.com provides access to resources such as program documents, on-demand pre-recorded provider training, and other pertinent information. These provider resources are

available to help your organization keep abreast of program details and processes. Our goal is to provide relevant information to assist your organization in providing quality, affordable services to members of covered health plans. Your feedback about this program, this manual, or your experience in working with eviCore to deliver these quality services is welcome and appreciated. Please email any comments or questions to us to the email address provided in the following paragraph.

Remember to visit our website to access the most current information regarding program changes. If at any time you need further clarification or support, please contact our Client and Provider Operations Department at clientservices@evicore.com, or contact the team via phone at 1-800-575-4517, option 3.

Corporate Overview

eviCore is one of the largest specialty benefits manager in the United States and offers proven, diversified medical benefits management solutions that focus on patient-centered care coordination. eviCore solutions are designed to help clients reduce costs while increasing the safety and quality of care for their members. The company provides these solutions to managed care plans and risk-bearing provider organizations serving Commercial, Medicare, and Medicaid populations. Powered by a team of specialized medical professional resources, extensive evidence-based guidelines, and advanced technologies, eviCore supports clients by working to enable the right care to be delivered at the right time to the right member at the right site of care.

eviCore operates nationally with employees primarily located in Bluffton, SC; Colorado Springs, CO; Melbourne, FL; and Franklin, TN. Innovative and flexible medical benefits management solutions are offered in: Cardiology, Comprehensive Oncology, Gastroenterology, Lab Management, Medical Oncology, Musculoskeletal, Post-Acute Care, Radiation Oncology, Radiology, Durable Medical Equipment, Home Healthcare, Sleep Management, Home Infusion Therapy, and Specialty Drug Management. On an annual basis, eviCore works with more than 250 million members with the goal of helping them receive higher quality and lower cost healthcare. For more information, please visit www.evicore.com.

eviCore's Provider Services Model

One way eviCore supports providers is to ensure the transparency and efficiency of our processes. The Client and Provider Service delivery team is responsible for maintaining high-level service delivery to your organization, including timely responses, issue tracking, and reporting of all issues. The team handles all inquiries via phone or email and coordinates key communications with affected departments. It also provides continuing education and helps ensure resolution through targeted research. Issues are handled by a team of cross-trained representatives, with the goal of providing prompt service to your inquiries.

Department	Email Address	Telephone Number
Client and Provider Operations Department	clientservices@evicore.com	1-800-575-4517, option 3

Onboarding Providers – Training

Onboarding Training includes important information on provider responsibilities and eviCore operational procedures regarding services for members as outlined in this manual. eviCore's Provider Engagement department will provide all training sessions, either at program launch or on request. Health plan specific provider resources and recorded training sessions can be found on the provider resource page at www.evicore.com. Providers can contact clientservices@evicore.com to request information regarding onboarding training availability.

eviCore's Confidentiality Standards

eviCore strives to maintain the highest standards related to the privacy of provider and delegated member information. Our employee code of conduct training is designed to ensure that all applicable confidentiality provisions are adhered to including HIPAA and that only the minimally required information is utilized to make appropriate determinations. All documents, data and knowledge of business and health care matters are maintained in a confidential manner.

Provider Manual

Participating network providers (PNPs) are valued partners in eviCore's operational framework. As a member of our network, you can expect clear and transparent communications and detailed preparatory training regarding processes and expectations. eviCore's strong commitment to service is manifested in direct support via dedicated resources, support staff, training materials, and established issue-resolution processes. This manual provides information about the policies and procedures that are applicable to any contracted PNP.

eviCore provides utilization review and care coordination programs to health plans. These programs are designed to help health plan members receive health care services that follow an evidenced based medicine approach and that facilitates coordinated care to avoid disruption and to help enable optimal service delivery. For each health plan, there may be slightly different utilization and/or Care Coordination processes that your organization must follow. Detailed processes will be provided through direct communications, trainings, health plan specific provider resource pages located on evicore.com and plan specific Addendums. Throughout each section, there may be references to specific health plan processes to ensure adherence.

This manual may be updated frequently; providers are encouraged to visit www.evicore.com to access the most recent information. Providers have a responsibility to ensure they are following the most up-to-date policies and procedures mandated by eviCore.

Provider Services Included in This Manual

Operational Guidance. This manual provides details on policies and procedures that are applicable to all lines of business unless otherwise specified. Plan-specific processes and terms will be outlined as program manual addendums. Each plan will provide a comprehensive listing of services and codes for each category listed below.

Care Coordination. These services involve purposefully organizing the timely delivery of a member's healthcare from one or multiple providers and sharing information among the care providers to help achieve an effective positive result across the continuum of care. Care coordination is designed to improve health outcomes by working to avoid care from multiple providers being delivered in silos, with the aim of reducing healthcare costs and eliminating duplicate services and missed starts of care instances. Care coordination is provided based on PNP request.

Durable Medical Equipment (DME). These services consist of the following categories of care, which is not an exhaustive lists of services: Durable Medical Equipment, Respiratory Services and Equipment, Home Medical Supplies, and Orthotics and Prosthetics.

Home Health Care Services (HH). This product coordinates and provides clinical services in the home; Skilled Nursing Care (including infusion drug administration by qualified nurses), Skilled Home Health Aide services, and Physical, Occupational and Speech Therapies.

Home Infusion Therapy (HIT). This offering includes the provision of nursing, drugs, and the supplies and functions to support infusion therapy in the home or Ambulatory Infusion Suite

(AIS). This includes coordination for both specialty pharmacy products and non-specialty infusion therapy.

Sleep Management Program services. These cover the episode of care for sleep apnea diagnosis and treatment as well as for ongoing compliance with treatment. The program manages sleep diagnostic procedures and positive airway pressure (PAP) therapy devices and supplies, delivering coordinated care along the sleep diagnostic and treatment continuum to ensure better member outcomes.

Provider Operational Standards and Requirements

The PNP agrees to:

- Provide eviCore with timely written notice of changes in its organization as required in its provider contract and this Provider Manual
- Provide covered services to members in the same manner, under the same standards, with the same time availability as offered to its other patients and shall not differentiate or discriminate in the treatment of any member because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, veteran status, handicap or source of payment
- Accept and treat all members effectively and respectfully regardless of members' linguistic, cultural, or other unique needs
- Coordinate oral and written language assistance services at no cost to the member for members with limited English proficiency. Services should include; interpreters, written materials for the visually impaired, and hearing impaired services.
- Ensure applicable staff training on standard operating procedure SOP adherence, diversity and inclusion trainings, and other trainings to support care continuity and service delivery
- Establish, maintain, and modify appropriate business continuity and disaster recovery programs as required by applicable law and to ensure delivery of services to members
- Maintain standard operational hours for members and providers to meet the medical needs and services of the members
- Notify eviCore of all FDA recalls and any other significant occurrence that impedes member care that negatively impacts health outcomes
- Adhere to all requirements listed in the eviCore PNP Agreement, and contractual relationships between eviCore and other applicable health plan clients

Notification of Contracted Provider Demographic Changes

All changes to the provider information that was included in the original agreement must be reported to eviCore prior to the effective date of the change. Major organizational changes should be provided in accordance with Exhibit C of the provider contract. Examples of

organizational changes that require notice are listed in the Notices section of the provider contract. It is the PNP's responsibility to report organizational changes directly to eviCore.

Process of Submitting a Precertification Request

To ensure seamless member care, it is critically important that the PNP clearly understands and adheres to responsibilities for timely delivery of member services.

Providers should verify eligibility and benefits through the member's health plan prior to providing services. Eligibility and benefit verification are not a guarantee of payment for services.

Providers should submit a precertification request to eviCore via the Provider Portal, phone, or directly through each health plan as detailed in specific training materials.

Information that is necessary to complete a precertification request includes, but is not limited to, the following:

- Member demographics
- Diagnosis
- Ordering physician's demographics
- Requesting provider's demographics
- Services requested, with HCPCS codes (if applicable)
- Start-of-care date
- Clinical documentation to support medical necessity
- Physician's orders (if applicable)

If any necessary information is missing, the request may be pended until the required information is received by eviCore.

Precertification must be completed prior to the service being provided. If a provider fails to obtain a precertification for a service, such service may not be reimbursed and will not be billable to the member. There may be exceptions for certain plans.

Utilization Management (UM)

The Utilization Management (UM) Process empowers the improvement of care for members by promoting appropriate, evidence-based decision making and quality measurement to help avoid overuse and underuse of medical services.

eviCore empowers the improvement of care for members by assisting providers in evidence-based decision making, while reducing administrative burdens and costs. The performance of UM decision makers is measured based on the consistent and appropriate application of

evidence-based decision making and quality measurement to the requested service. eviCore does not reward agents on redirection rates or denial rates.

UM decisions are made independently and impartially. They are based on, but not limited to, the following:

- The specifics of the contract between the provider and/or eviCore and the applicable payor
- The provisions of the members' health plan
- eviCore Proprietary Evidence-Based Clinical Guidelines (Sleep Management)
- CMS' Medicare Benefit Policy Manual, if applicable
- National and Local Coverage Determination Guidelines
- State Medicaid Guidelines, if applicable
- MCG Care Guidelines – MCG™, if applicable

Each health plan will determine whether UM reviews will be provided via eviCore or directly by the health plan itself. eviCore will provide specific details on UM processes in the provider trainings and on the provider resource page for each specific health plan.

Centers for Medicare & Medicaid Services (CMS) Notice of Medicare Non-Coverage Requirement

As applicable, PNPs are required to comply with applicable state and federal laws. With respect to Medicare members who are discharged from home health care, CMS requires providers to implement the timely issue of a Notice of Medicare Non-Coverage (NOMNC) to the member unless an exception to the NOMNC requirement applies. PNPs are required to adhere to CMS standards for NOMNC to members who are discharged based on the lack of medical necessity.

Portal Capabilities and Support

Using eviCore Web-Based Services is the fastest, easiest, and most efficient way to obtain prior-approval. Providers can access the eviCore provider portal by visiting the appropriate website for the health plan.

The eviCore provider portal is available for access 24/7 and enables providers to:

- Initiate a precertification request
- Submit clinical information for concurrent precertification requests
- View and manage all pending and recently submitted cases on the user dashboard
- View and print real-time letter determinations for each case

- Export and save all authorization documents
- View pertinent eviCore announcements and notifications

Any questions and/or concerns regarding the web portal should be directed to Web Support by calling 1 (800) 646-0418, option 2 or emailing Portal.Support@eviCore.com

Call Center Availability

eviCore Call Center hours will be determined by each health plan. Providers will be able to call eviCore directly and, by selecting the appropriate prompts, initiate actions and requests such as the following:

- Request prior approval
- Check case status
- Provide additional clinical information

Urgent Guidelines

To reduce denial, a request **should not be submitted as "urgent"** unless it meets the NCQA/URAC definition of Urgent: when a delay in decision-making may seriously jeopardize the life or health of the member. **Urgent** request determinations will be rendered within 72 hours and will be based solely on clinical information received within that timeframe. Each health plan will specify timelines and processes for cases submitted with an **urgent** status.

Retrospective Review Requests

Retrospective precertification requests are not usually allowed; however, each health plan's policy on such reviews will provide details on the submission of retrospective reviews.

Post-Denial Reconsideration

Commercial and Medicaid Members Only

Reconsideration is a post-denial, pre-appeal opportunity to provide additional clinical information. Once a service has been denied, Commercial and Medicaid members can request determination reconsideration. Reconsiderations must be requested within 7-14 calendar days from the denial determination date, depending on the provisions of the member's health plan and applicable state and federal guidelines. Each health plan will determine the process of handling reconsideration case reviews. eviCore's provider training materials will specify the details of these processes.

Appeals Process for a Denied Service

Once a service has been denied, members and providers must file an appeal to have the request re-reviewed. Each health plan will specify the detailed process that providers must follow to submit appeals for denied services. Per industry standard, the denial rationale and appeal process will be communicated via written notice to the requesting provider.

For Commercial members, each health plan will specify the timelines and processes for review of appeals cases. With respect to Medicare and Medicaid members, the turnaround time after an appeal has been requested by the member is up to 72 hours for an *expedited* appeal and up to 30 days for a *standard* appeal. Requests for expedited appeals must meet CMS guidelines, i.e., when a delay in decision-making may seriously jeopardize the life or health of the member.

Each health plan will maintain specific requirements regarding Appeals for Denied Service. It is the responsibility of the PNP to review and adhere to the policies of the specific health plan prior to rendering member services.

eviCore training sessions and the health plan's provider resource page will provide detailed information regarding appeal processes and timelines for submission and determinations.

Provider Complaints

For complaints involving eviCore policy, protocol, or staff members, providers can submit written notification outlining the complaint to eviCore's Quality Management (QM) Department. The QM Department will research and review the complaint. Once the review is complete, eviCore's determination will be forwarded to the provider in writing. Written complaints are accepted by fax at: 866-699-8160. Each health plan will provide details on submission of provider complaints in the addendum and program training materials.

Credentialing and Re-Credentialing

All contracted facilities are subject to the eviCore Network Standards applicable to the services they provide and the credentialing and re-credentialing process delegated to eviCore.

Initially and every 36 months thereafter, Home Health (HH) Agencies, Home Infusion Therapy (HIT) Agencies, and DME suppliers must complete the eviCore "Facilities Credentialing Application." Questions regarding an application or the credentialing process can be directed to the eviCore Client Services team at clientServices@evicore.com (preferred) or 1-800-575-4517, option 3.

Reimbursement Rates

Providers can email clientservices@evicore.com for details regarding the DME fee schedule. Fee schedules can also be posted on the health plan-specific provider resource page, visit: https://www.evicore.com/resources and search for each applicable health plan to locate available information regarding fee schedules. For HHs and HITs, the fee schedule is included in the contract.

Claims Submission

The responsibility for claims processing will be dependent on the terms of the health plan contract. For specific claims-processing details, please refer to Exhibit A of the PNP agreement.

Providers are required to enroll in Electronic Fund Transfer (EFT) to receive payment for services rendered by a health plan. EFT forms can be requested and returned to clientservices@evicore.com via email or faxed to the number on the form.

For claims submissions, providers should send claims directly to the health plan as indicated on the member ID card. Providers should submit claims as professional changes via Paper using (CMS1500) or Electronic (837p). All inquiries regarding claims submissions should be directed to the health plan.

For select members, Cigna will partner with eviCore healthcare for claims processing for Durable Medical Equipment, Home Health Services, and Home Infusion Therapy. The claims submission process does not change from that outlined above. Cigna will notify the provider, via the provider remittance if a claim is part of this arrangement, with a message that the claim has been forwarded to eviCore. For questions concerning claims on file with eviCore, the PNP can contact our customer service team at 888-693-3296 (option 2) or view the claim via the portal at www.eviCore.com

Program-Specific Details

In this section, eviCore provides a general overview and description of program offerings for Care Coordination, Home Health, Home Infusion Therapy, Durable Medical Equipment, and Sleep PAP Therapy Device Management Program – TherapySupport. eviCore manages member care for multiple health plans and therefore, there may be variations in program offerings to accommodate the individual differences of each health plan.

Care Coordination

Care Coordination involves deliberately organizing the timely delivery of a customer's healthcare from one or multiple providers and sharing information among the care providers to help achieve an effective positive result across the continuum of care. Care Coordination is designed to improve health outcomes by helping to ensure that care from multiple providers is not delivered in silos, healthcare costs are reduced, duplicate services are eliminated, and missed starts of care are avoided. Care Coordination is provided based on the PNP request directly to eviCore.

Care Coordination includes

- Easy and timely access to in-network home health care services and providers
- Tightly managed performance metrics with national participating home health service providers
- Service validation with the customer to verify on-time start of care
- Focus on the total healthcare needs of the customer
- Clear and simple information that the customer can understand
- Administrative simplification for the referring provider
- Additional layer of management to help prevent fraud, waste, and abuse

Examples of Care Coordination

- Helping the ordering provider find In-Network (INN) servicing providers
- Follow up with the servicing provider when equipment is not delivered on time
- Follow up with customer to validate that the servicing provider delivered equipment or it arrived at home when missed starts of care have been an issue
- Working with eviCore Case Manager when eviCore knows the situation in the home requires monitoring to verify that the customer is receiving timely delivery of their supplies or equipment on an ongoing basis

Home Infusion Therapy (HIT)

The Home Infusion offering includes the provision of nursing, drugs, and supplies to support infusion therapy in the home or Ambulatory Infusion Suite (AIS). This includes the coordination for both specialty and non-specialty pharmacy products that are administered through Home Infusion Therapy services. Each health plan will specify the method of precertification and eviCore will provide training sessions to educate providers on the process. All information for these services will be located on the specific health plan's resource page.

Home Health (HH) Services

The Home Health program is a member-centric program that assesses not only the clinical appropriateness of home health services, but also each member's unique home environment and psychosocial factors, to determine whether the member's home is the most appropriate setting for recovery. The program works to ensure that services are initiated in a timely manner, and that the member receives the right number of visits, with the right disciplines, from the provider best equipped to deliver the needed services. The specific areas of HH services that require UM will vary by the plan.

Home Health program includes**

- Skilled nursing care
- Skilled home health aide services (for members receiving skilled HHC services)
- Physical therapy (PT)
- Occupational therapy (OT)
- Speech-language pathology (ST)
- Medical social services

**Each health plan will determine the services included in the HH program.

Home Health Submission Requirements

- Member demographics
- Ordering physician demographics, including NPI number and contact information
- Home Health Agency provider demographics, including NPI and contact information

- Clinical documentation

Home Health Clinical Documentation

Providing adequate clinical information is essential when requesting precertification for medical necessity determination. The following clinical information is required when requesting prior approval for Home Health Services:

- Services requested (number of visits/frequency/HH aide hours)
- Diagnosis codes
- Mobility and functional status (recent PT/OT/ST notes)
- Medications List
- Start of care and anticipated end dates
- Verified Clinical Documentation supporting medical necessity

Home Health Date Extensions and Discharge Planning

HH Providers should submit discharge plans, including discharge barriers if applicable, and anticipated date of discharge, when submitting clinical information for date extension requests.

With respect to Medicare Advantage members, HH Providers should submit clinical for date extension requests 72 hours prior to the last covered day, to allow time for Notice of Medicare Non-Coverage (NOMNC) to be issued.

Durable Medical Equipment (DME)

DME is any equipment that provides a member therapeutic benefits that are needed because of certain medical conditions and/or illnesses.

Durable Medical Equipment (DME) consists of items that

- Primarily and customarily are used to serve a medical purpose
- Are not useful to a person in the absence of illness or injury
- Are ordered or prescribed by a physician
- Are reusable
- Can stand repeated use
- Are appropriate for use in the home

DME Submission Requirements

- Member demographics

- Ordering physician demographics, including NPI number and contact information
- Clinical Documentation
- DME Provider demographics, including NPI and contact information
- Request type (rental or purchase)

DME Clinical Documentation

The provision of adequate clinical information is essential when requesting prior-approval through eviCore. Furnishing the key pertinent clinical information will help eviCore determine medical necessity.

The following clinical information is required when requesting prior approval for Durable Medical Equipment:

- Dated and detailed written order (if applicable)
- Diagnosis and HCPCS Code(s)
- Verified Clinical Documentation supporting medical necessity
- Sleep test results, if applicable

DME Continuity of Care

For members who have a current approval for DME rentals or purchase prior to program implementation, or have a change in health plan coverage, the Continuity of Care (CoC) process will apply. When requesting additional authorizations for CoC, clinical documentation will be required. Specific required information should be coordinated with the applicable health plan or eviCore.

DME Applicable CPT/HCPCS Codes

To find a complete list of DME Current Procedural Terminology (CPT) codes and Healthcare Procedural Codes (HCPCS) that require precertification through eviCore, please visit: https://www.evicore.com/resources and search for each applicable health plan. Also, review the plan-specific addendum for the codes that require precertification by each plan.

Sleep PAP Therapy Device Management – TherapySupport℠

eviCore's TherapySupport Program manages the utilization of, and adherence to, positive airway pressure (PAP) therapy devices.

TherapySupport: eviCore's PAP Therapy Management Process

As part of our TherapySupport Program we objectively monitor PAP usage, and intervene with DME and physician providers when members are determined to not be meeting targeted usage levels. eviCore gathers PAP usage data from online systems to monitor member usage and compliance with therapy. When a member is confirmed to not be compliant with PAP therapy, an eviCore sleep educator contacts the DME provider and the treating physician via fax to support effective treatment of obstructive sleep apnea. Once eviCore receives compliance

information, providers can access the data in the eviCore portal to view PAP usage and adherence to therapy.

Registration of PAP devices with eviCore

- DME providers will need to contact eviCore to register PAP therapy devices before they are dispensed to the health plans members. Registration can be obtained by contacting eviCore via online portal or by telephone. Initial PAP therapy registration consists of three monthly rental units. During the initial 90-day period, device-generated member-compliance data will be monitored by eviCore. The DME provider is expected to continue to work with the member during this time period to maximize member compliance with PAP therapy.
- When the member reaches compliance for PAP therapy in accordance with eviCore criteria, the DME provider will be able to bill Cigna for the remaining three rental units, which will result in member ownership of the device. eviCore will send notification to the health plan that the member has met criteria.

PAP Compliance requirements

"PAP Compliant Members" are defined as members who use prescribed PAP equipment an average of 4.0 hours or more per night for seventy percent (70%) of nights over a thirty (30) day period, during the first ninety (90) days of treatment. "Non-PAP Compliant Members" are defined as Members for whom PAP equipment has been registered, but who do not meet the definition of PAP Compliant Members after 90 days of use.

- **Compliance Communications for non-compliant members.** If members are not meeting compliance goals at 3, 7, 21, 30, 60, or 90 days after starting treatment, eviCore will communicate with the DME Provider and/or the Member's Physician via fax informing the provider of the member's status.
- **Continued rental to purchase.** Payment of claims for continued rental to purchase beyond the first 3 monthly payments will be dependent on the establishment of compliance during the first 90 days. If a member is not compliant during the first 90 days, claims will not be paid beyond the first 3 monthly rental units.

Sleep Provider PAP Therapy Compliance Expectations

- DME providers are expected to work diligently with members in the treatment of diagnosed sleep apnea
- DME providers must be able to demonstrate compliance monitoring for > 90% of their members
- DME providers should work to maximize compliance for all members to ensure the majority are 70%, or greater, compliant with PAP equipment within 90 days of member registration as defined above ("PAP compliant members"). This calculation will be based on all members for whom eviCore has confirmed compliance during the first 90 days of use as a percentage of all members for whom an initial registration for PAP equipment was given and PAP usage was detected by eviCore.

Provider Performance Levels and Metrics

To ensure PNP's service levels are conducted in an optimal manner, the following metrics should be submitted via a secure drop box based on stated frequency: monthly or quarterly. PNP service level reports are due by the 5th business day of the following month, respectively; annual reports are due by February 15th. FDA or state sanctions should be reported immediately via both drop box and email to clientservices@evicore.com

All Program Metrics:			
Area	**Elements to Report**	**Performance Thresholds**	**Report Frequency**
Member Satisfaction	Overall Combined Score	**90%**	**Quarterly**
	Staff Courtesy	**95%**	**Quarterly**
	Staff Timeliness of Service	**95%**	**Quarterly**
Member Complaints	Complaint Ratio (Members Serviced to Complaint Received)	**<5%**	**Monthly**
Provider Satisfaction	Overall Satisfaction Score	**85%**	**Annual**
Provider Complaints	Complaint Ratio (Members Serviced to Complaint Received)	**<5%**	**Monthly**
Provider Resolution	Complaints resolved within 48 hours	**95%**	**Monthly**
Reporting	Report delivery by 5th business day of the month	**100%**	**Monthly**
Federal/State Program Sanctions	Formal sanctions received by the organization due to inadequate quality or performance	**0%**	**Report within 24 hours of Receipt**
Service Delivery			
Provider Availability	Provider available during normal business hours for non-emergent start of care	**100%**	**Monthly**
	Provider available for holiday start of care/service according to eviCore or payor's holiday schedule	**98%**	**Monthly**
Timely Delivery	Percent of services initiated within 48 hours after request by referring provider/receipt of authorization as applicable	**98%**	**Monthly**
	Emergent care initiated within 4 hours of request by referring provider or receipt of authorization as applicable	**98%**	**Monthly**
Service Complaints	Complaints against delivery personnel ratio	**<2% of all deliveries**	**Monthly**
Missed Start of Care/Service Ratio	Care/Service not started within timeframe scheduled/requested/ Provider has accepted case and case is not initiated by scheduled time	**<2%**	**Monthly**
Early Withdrawal Ratio	Members who withdraw from services due to service delivery issues	**<2%**	**Monthly**
Turn Back	Provider accepted the case but now is unable to provide service	**<2%**	**Monthly**

Disaster Plan	Provide disaster plan on request for any pending or actual disaster or annually	**100%**	**Annually**
Home Health Specific Program Criteria:			
Notice of Medicare Non-coverage (NOMNC) applicable to Medicare Only	Signed NOMNC obtained for covered members and submitted to eviCore	**90%**	**Monthly**
First Home Health Visit	First Home Health visit to be completed within 48 hrs of discharge to home for authorized members	**95%**	**Monthly**
Sleep-Specific Program Criteria:			
Sleep Compliance Monitoring	DME Providers must register members with eviCore prior to providing equipment	**90%**	**Quarterly**
	DME Providers must adhere to PAP device set-up processes in manufacturers' online systems to ensure eviCore receives member data appropriately	**90%**	**Quarterly**
	DME Providers should ensure their members are compliant with PAP therapy during the first 90 days of therapy (% compliant = PAP-compliant members/all members registered with eviCore)	**>70%**	**Quarterly**