Durable Medical Equipment

CountyCare Health Plan

Frequently Asked Questions

Who is eviCore healthcare?
eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides Durable Medical Equipment (DME) utilization management services for CountyCare Health Plan members.

Which members will eviCore healthcare manage for DME?
Beginning October 30, 2023 eviCore will accept DME prior authorization requests for members with coverage through CountyCare Health Plan for dates of service November 1, 2023 and beyond.

Which DME services require prior authorization?
To find a complete list of DME Healthcare Procedural Codes (HCPCS) that require prior authorization through eviCore, please visit our Provider Resource site: www.evicore.com/resources/healthplan/countycare

How does a provider check member eligibility and benefits?
Providers should verify member eligibility and benefits on the secured provider log in section on the CountyCare Health Plan provider portal www.countycare.com/providers/portal or by calling the CountyCare Provider Service line at 312.864.8200.

Eligibility may also be verified at www.evicore.com/pages/providerlogin.aspx during the prior authorization process.

How does a provider initiate a prior authorization request?
Providers and/or staff may request prior authorization in one of the following ways:

- **eviCore Provider Portal (preferred)**
  The eviCore portal is the quickest, most efficient way to request prior authorization. Providers can request a prior authorization by visiting www.evicore.com/pages/providerlogin.aspx.
- **Fax**
  Prior authorization requests for DME may be faxed to 866.663.7740
- **Phone**
  Providers and/or staff may request prior authorization by calling 866.525.5029.

Where can a provider find DME prior authorization request forms?
DME prior authorization forms are available on the eviCore provider resource website:
https://www.evicore.com/resources/healthplan/countycare

How does a provider check the prior authorization status for a member?
Prior authorization status can be viewed on demand via the eviCore portal at www.evicore.com/pages/providerlogin.aspx or by calling eviCore at 866.525.5029.

What are the eviCore hours of operation?
eviCore hours of operation are:

- Monday – Friday 7 a.m. to 8 p.m. CST
- Saturday 8 a.m. to 4 p.m. CST
- Sunday 9 a.m. to 1 p.m. CST
- Holidays 9 a.m. to 1 p.m. CST
- 24-hour on-call coverage

Who is responsible for submitting the initial DME prior authorization request?
Typically, the provider supplying the DME item is responsible for submitting the prior authorization request. However, ordering physicians and staff of said physician can also submit the prior authorization request.

What are the prior authorization requirements?
To obtain prior authorization on the very first submission, the provider submitting the request will need to gather four (4) categories of information:

- Member
  - Member Medicaid ID
  - Member name
  - Date of Birth (DOB)
- Rendering Facility
  - Facility name
  - National provider identifier (NPI)
  - Tax identification number (TIN)
  - Phone & Fax number
- Referring Physician
  - Physician name
  - National provider identifier (NPI)
  - Tax Identification Number (TIN)
  - Phone & Fax number
- Supporting Clinical Information
  - Current physician's order/script
  - Current clinical information relating to the request (i.e., patient history, progress notes and physical exams)
  - Current detailed invoice listing all requested equipment

Requirements are outlined on the eviCore prior authorization request form.
https://www.evicore.com/resources/healthplan/countycare

To ensure the prior authorization process is completed as quickly and efficiently as possible, it is strongly recommended that providers submit pertinent clinical information to substantiate medical necessity for the type of service being requested.

When will a provider receive the prior authorization determination from eviCore?
If all information is provided when the request is submitted a typical response is within two business days for routine requests, but no longer than the 4 day calendar day limit and no later than 48 hours for urgent requests.

How will prior authorization determinations be communicated to providers?
eviCore will communicate the determination utilizing the following methods:

- Witten notification will be faxed or provided via e-notification to the ordering physician and the DME supplier
- Prior authorization status can be viewed on demand on the eviCore portal at: www.evicore.com/pages/providerlogin.aspx.

When does the initial prior authorization approval expire?
Prior authorization for purchases are usually valid for 180 days and daily rentals are usually valid for 90 days. Monthly rentals are valid for how many units are approved.

What if a member is in the acute setting or a facility and needs DME?
This program is home-based and therefore any equipment needed for the member in a facility wouldn't be part of this program. If DME is contingent on the member's discharge, typically the facility and or physician should submit a referral to a DME supplier. In some cases, the facility can make authorization requests to eviCore if needed. The preference is the DME supplier initiates the request with eviCore.

What is the process when additional information is needed to meet clinical criteria for a DME service?
eviCore will fax a hold letter to the ordering and servicing provider requesting additional information. The provider should submit the additional information to eviCore within the timeframe specified in the letter. eviCore will review the additional documentation and reach a determination.

What is the process if a DME service does not meet clinical criteria?
When a request does not meet medical necessity based on evidence-based guidelines, an adverse determination is made, and the request is denied. In those cases, eviCore will send a denial letter with the rationale for the decision, peer-to-peer options, and appeal rights will be sent to the physician, DME supplier, and member.

In the event of an adverse determination, what post-denial processes are available?

- The provider has 2 business days to submit a peer-to-peer request by phone or in writing.
- After 3 business days, the request would be considered an appeal and the provider should follow the appeal process.
- eviCore has 1 business day to complete the peer-to-peer telephonic process.
- eviCore has 5 calendar days to complete the written peer-to-peer request.
- Decisions can be overturned, partially overturned, or upheld, and additional information may be submitted.

Appeal Process

- eviCore will process first-level appeals. Second-level appeals will be managed by CountyCare Health Plan.
- The process and timeframe to submit an appeal request will be outlined in the determination letter.
- The appeal address and phone number will be provided in the determination letter.
- Members or providers with appeal questions may call the eviCore's dedicated call center at 855.754.5527.
- The first level appeal determination will be communicated by eviCore to the ordering provider and member.
- Appeal turnaround times:
    - Expedited typical response time is 24 hours (not to exceed 72 hours)
    - Standard 15 business days

Medicaid members requesting an appeal of the denial for continued DME services should follow the process outlined on their denial letter.

Does eviCore review cases retrospectively if no authorization was obtained?
For any requests for prior authorization that are received for services already rendered, prior authorization should not be provided except under specific circumstances. Retrospective requests will only be accepted based on HCPCs code and CountyCare allowable exceptions presented during the request.

What if a prior authorization is issued and revisions need to be made?
The ordering physician or servicing DME supplier should contact eviCore with any changes. It is important to notify eviCore of any changes in order for claims to be correctly processed for the servicing DME supplier.

How do providers submit a program-related question or concern?
For program-related questions or concerns, please email clientservices@evicore.com or call 800.575.4517 (option 4).

Who should providers contact for portal support/questions?
To speak with a portal specialist, please call 800.646.0418 (Option 2) or email portal.support@evicore.com.
Our dedicated Portal Support team can assist providers in navigating the portal and addressing any portal-related issues during the online submission process.

Where can providers find additional information?
For more information and reference documents, please visit eviCore's provider resources site for this program:
https://www.evicore.com/resources/healthplan/countycare