EviCore By EVERNORTH

Frequently Asked Questions

VAYAHEALTH

Durable Medical Equipment

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 Medicaid Vaya Total Care members.

Which customers will EviCore healthcare manage for DME?

EviCore healthcare (EviCore) will begin accepting prior authorization requests for Durable Medical Equipment (DME) services on June 17th, 2024 for Vaya Health members with Medicaid coverage for dates of service of July 1st, 2024 and beyond.

Which DME services require prior authorization?

Prior Authorization Services applies to DME services that are home based and medically necessary.

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 Vaya provider portal Vaya Health - Provider Central or by calling the Vaya Provider Service line at 866.990.9712.

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 Homepage | EviCore by Evernorth
- **Fax**
  Prior authorization requests for DME may be faxed to 866.663.7740.
- **Phone**
  Providers and/or staff may request prior authorization by calling 855.754.5527.

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/vayahealth.

What are the EviCore hours of operation?

EviCore hours of operation are:

- Monday – Friday 9 a.m. to 9 p.m. EST
- Saturday 9 a.m. to 5 p.m. EST
- Sunday 9 a.m. to 2 p.m. EST
- Holidays 9 a.m. to 2 p.m. EST
- 24-hour on-call nurse 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

When will a provider receive the prior authorization determination from EviCore?

Once all information is submitted, EviCore will outreach to the provider with a determination. Typical response time is two business days for routine requests and no later than 72 hours for urgent requests.

How will prior authorization determinations be communicated to providers?

EviCore will communicate the determination utilizing the following methods:

- Written notification will be faxed to the ordering physician and the DME supplier.
- Prior authorization status can be viewed on demand on the EviCore portal at Homepage | EviCore by Evernorth.

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When does the initial prior authorization approval expire?

Purchases are usually valid for 180 days but can be up to 365 days if guidelines allow. Monthly rentals are usually valid how many units/months approved.

For continued rentals and purchase a future DOS, up to 30 calendar days from date of submission of the PA, can be requested. This should not be requested > 30 days prior to existing authorization expiration date. This helps eliminate authorization time-frames from overlapping.

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 to the physician, DME supplier, and member.

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

Peer-to-Peer

- Providers have 3 business days after the determination date to submit a request
- Requests can be submitted in writing or verbally via a Clinical Consultation with an EviCore physician
- Decisions can be overturned, partially overturned, or upheld, and additional information may be submitted.
- After 3 business days, the appeal process must be followed.

Appeal Process

- EviCore will process first-level appeals. Second-level appeals will be managed by Appeals Support and Fair Hearing Support.
- The process and timeframe to submit an appeal request will be outlined on the determination letter, as well as the appeal address and phone number.
- 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 30 day

Frequently Asked Questions

Does EviCore review cases retrospectively?

Retrospective reviews will be allowed up to and including September 29th, 2024 to assist with the transition to Vaya's Tailored Plan, Vaya Total Care. On September 30th, 2024 and beyond, retrospective reviews will only be allowed if due to a member's retroactive enrollment.

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: Vaya Health Provider Resources | EviCore by Evernorth