

March 2026



---

New Prior Authorization requirements with EviCore by Evernorth effective April 1, 2026

Effective April 1, 2026, Network Health is expanding its partnership with EviCore by Evernorth, and new prior authorization requirements will be added for the following services:

- Site of Care program for Medical Oncology services for Commercial and ACA members.

This requirement is specific for oncology treatment delivered in a hospital setting (outpatient). Providers will be directed to choose a non-hospital / preferred site of service. When a hospital or non-preferred site is selected, the requester will be required to select an appropriate exception reason to be assessed by an EviCore clinical reviewer. Services performed in conjunction with an inpatient stay, 23-hour observation or emergency room visit are not subject to authorization requirements.

As shared in previous articles, EviCore by Evernorth has been leading orientation sessions designed to assist you and your staff with this new prior authorization program. One orientation session remains. If you have not attended an earlier session, we encourage you and your teams to attend to ensure your understanding of the prior authorization process and changes. Orientation sessions require advance registration, and the training will last approximately one hour. [Please click here for more information](#) on how to register and to select training dates that work best for your schedule.

---

## Authorization Turnaround Times

Beginning January 1, 2026, the authorization turnaround times have changed.

- Medicare urgent/emergent inpatient hospital admission requests changed from 14 calendar days to 72 hours.
  - This change was due to the CMS update to the definition of organization determination in the 2026 Final Rule.
- Medicare standard, non-urgent requests changed from 14 calendar days to 7 calendar days.
  - This change was part of the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).

Please include all relevant medical documentation with your requests to avoid additional outreach to your staff and avoid denials due to lack of necessary information. Additionally, while we are meeting the regulatory timeframes and requirements, you may be experiencing longer turnaround times on prior authorizations requests than what you are accustomed to.

Due to our successful open enrollment, we are experiencing a higher volume of prior authorization requests, and we appreciate your patience as we work through the impact of these changes. If you have any questions regarding this information, please reach out to your provider operations manager.

---

### Provider Operations Team

At Network Health, all of our provider partners are assigned a dedicated provider operations manager. They are available to support providers with onboarding, including registration on our provider portal and reviewing our payment policies and authorization requirements. They also serve as a liaison between our Claims, Member Experience and Utilization Management teams, and are responsible for all contracting questions post signature. If you are unsure who your specific contact is, please [reach out to Jill Stoken](#) for additional information. We look forward to hearing from you!

---

### Updated Payment Policies

- The **Cancelled Claim Policy** was updated to align with our Claim Submission Policy.
- The **Claim Submission Policy** was updated stating providers should not submit UB04/Facility corrected claims under bill type XX5/Late charges.
- The **Lesser of Policy** was updated to reflect that “lesser of” is determined by the lower of the provider’s billed charges per line or the contractual and/or fixed rate.
- The **Robotic Assisted Surgery Policy** has been updated, removing the experimental/investigational language and incorporating additional codes to the table on page 2.
- The **Un-bundling Policy** has been updated to include all lines of business in the always-bundled code list.

[Please click here](#) to review a complete list of our Claims Policies and Procedures.

If you have questions regarding any of the policy updates, please reach out to your provider operations manager.

---

### MDPP Elevator Speech

Nearly half of American adults aged 65 or older have prediabetes. Without weight loss or routine moderate physical activity, many of them will develop type 2 diabetes within a few years. People with prediabetes are also at higher risk of having a heart attack and stroke. The Medicare Diabetes Prevention Program (MDPP), offered by Network Health, can help make lasting changes to prevent type 2 diabetes and improve overall health. The program is free for participants who are enrolled in Medicare or Medicare Advantage plans and it is part of the National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC). It is backed by years of research showing that program participants aged 60 and older can cut their risk of type 2 diabetes by 71 percent—by losing weight, eating better, and being more active.

Participants will receive a full year of support from a lifestyle coach and peers with similar goals, along with tips and resources for making lasting healthy changes. The program provides weekly 1-hour core sessions for up to 6 months and then monthly sessions for the rest of the year. Participants will also learn how to manage stress, set and achieve realistic goals, stay motivated, and solve problems. Participants may even

be able to manage other conditions like high cholesterol or high blood pressure with fewer medications.

---

### Appointment Access Requirements

As a reminder, as part of our NCQA accreditation, our providers must meet the following appointment access times in order for us to maintain our accreditation. Here are the appointment access standards that must be met.

#### **For Primary Care Services**

1. Regular or routine care within 60 days of request
2. Urgent care appointment within 48 hours of request

#### **For Specialist Services**

1. Care within 30 days of the request
2. Non-life threatening, urgent appointment within 48 hours of request

#### **For Behavioral Health Services**

1. Non-life-threatening emergency within 6 hours of request
2. Urgent care appointment within 48 hours of request
3. Initial visit for routine care within 10 business days of request
4. Follow up appointment for a routine care visit within 30 days of request

Additionally, you must have an answering service, on-call provider, or message to direct patients to the emergency room for after-hours calls.