National Imaging Associates, Inc. (NIA)
Frequently Asked Questions (FAQ's)
Managed Health Services (MHS)
Prior Authorization Program
Physical Medicine Services

Question	Answer
General	
When does the Physical Medicine Services program transition to a Prior Authorization program for MHS?	Effective July 1, 2019, physical medicine services (physical therapy, occupational therapy and speech therapy) will no longer be managed through a post-service review process for MHS. MHS remains committed to ensuring that physical medicine services provided to our members are consistent with nationally recognized clinical guidelines. The utilization management of these services will continue to be managed by NIA through a prior authorization program.
What services now require prior authorization?	Prior authorization will be required for all treatment rendered by a Physical Therapist, Occupational Therapist, or Speech Therapist for a MHS Member.
Will a prior authorization be required for the initial evaluation?	The CPT codes for PT and OT initial evaluations do not require an authorization. However, all other billed CPT codes even if performed on the same date as the initial evaluation date will require authorization prior to billing. All Speech Therapy codes require authorization.
Which MHS members will be covered under this relationship and what networks will be used?	NIA's prior authorization program applies to MHS' Medicaid members including Healthy Indiana Plan (HIP), Hoosier Care Connect (HCC), and Hoosier Healthwise (HHW). **The prior authorization program does not apply to Ambetter and Allwell members.** NIA will manage Physical Medicine Services for all MHS Medicaid members who will be utilizing Physical Medicine services (Physical Therapy, Occupational Therapy, Speech Therapy).
Is prior authorization necessary for Physical Medicine Services if MHS is NOT the member's primary insurance?	No.

What services are included in this Physical Medicine Program?	All outpatient Physical Therapy, Occupational Therapy, and Speech Therapy services are included in this program in the following setting locations: • Outpatient Office/Facility • Outpatient Hospital • Home Health
Which services are excluded from the Physical Medicine Program?	Therapy provided in Hospital ER, during an Inpatient or Outpatient stay, Inpatient and Observation status, Acute Rehab Hospital Inpatient, and Inpatient and Outpatient Skilled Nursing Facility settings are excluded from this program. The treating provider should continue to follow MHS' policies and procedures for services performed in the above settings
Why is MHS implementing a physical medicine utilization management program?	This physical medicine solution is designed to promote evidence based and cost effective Physical Therapy, Occupational Therapy, and Speech Therapy services for MHS members.
How are types of Therapies defined?	Rehabilitative Therapy – Is a type of treatment or service that seeks to help a patient regain a skill or function that was lost as a result of being sick, hurt or disabled. Habilitative Therapy – Is a type of treatment or service that seeks to help patients develop skills or functions that they didn't have and were incapable of developing on their own. This type of treatment tends to be common for pediatric patients who haven't developed certain skills at an age-appropriate level. The simplest way to distinguish the difference between the two is Habilitative is treatment for skills/functions that the patient never had, while Rehabilitative is treatment for skills/functions that the patient had but lost. Neurological Rehabilitative Therapy – Is a supervised program of formal training to restore function to patients who have neurodegenerative diseases, spinal cord injuries, strokes, or traumatic brain injury.
What types of providers will potentially be impacted by this physical medicine program?	Any independent providers, hospital outpatient, and multispecialty groups rendering Physical Therapy, Occupational Therapy, and/or Speech Therapy services will need to ensure prior authorization has been granted. This program is effective for all services rendered on or after July 1, 2019 for all MHS membership.

Prior Authorization Process	
How will prior authorization decisions be made?	NIA will make medical necessity decisions based on the clinical information supplied by practitioners/facilities providing physical medicine services. Decisions are made as quickly as possible from submission of all requested clinical documentation (three days for urgent requests). All decisions are, at minimum, rendered within State required timelines. Peer-to-peer telephone requests are available at any point during the prior authorization process. NIA's clinical review team consists of licensed and practicing Physical Therapists, Occupational Therapists, Speech Therapists and board-certified physicians. Clinical determinations are rendered only by clinical peer reviewers with appropriate clinical experience and similar specialty expertise as the requesting provider. Clinical peer reviewers will be available for peer-to-peer requests as necessary consultation as needed. The MHS appeals process will be available if a provider disagrees with a prior authorization determination.
Who is responsible for obtaining prior authorization of the procedure?	Responsibility for obtaining prior authorization is the responsibility of the physical medicine practitioner/facility rendering and billing the identified services. A physician order may be required for a member to engage with the physical medicine practitioner, but the provider rendering the service is ultimately responsible for obtaining the authorization based on the plan of care they establish. Approval and denial letters are sent to the member, and physical medicine practitioner. MHS contracts generally do not allow balance billing of members. Please make every effort to ensure that prior authorization has been obtained prior to rendering a physical medicine service.
Will CPT codes used to evaluate a member require prior authorization?	Initial PT and OT evaluation codes do not require authorization. All Speech Therapy codes will require authorization, including evaluation codes, as these codes may be billed on a recurrent basis as part of ongoing treatment and will require an authorization at that time. It may also be appropriate to render a service that does require authorization at the time of the evaluation. After the initial visit, providers will have up two days to request approval for the first visit. If requests are received timely, NIA is able to backdate the start of

	the authorization to cover the evaluation date of service to include any other services rendered at that time.
What will providers and office staff need to do to get a physical medicine service authorized?	Providers will contact NIA using the RadMD website, www.RadMD.com or calling 1-866-904-5096 to obtain authorization for physical medicine services effective July 1, 2019. Prior authorization is required for members that are currently receiving care which will continue on or after July 1, 2019. NIA will begin accepting requests on June 21, 2019 for ongoing services that will continue into July. Authorizations obtained during this pre-launch period will reflect an effective date of July 1, 2019. Call center hours are 8 a.m. to 8 p.m. (EST) Monday through Friday. RadMD is available 24 hours each day, 7 days a week.
What kind of response time can providers expect for prior-authorization of physical medicine requests?	NIA does leverage a clinical algorithm to assist in making real time decisions at the time of the request based on the requestors' answers to a few simple clinically based questions. If we cannot offer immediate approval, generally the turnaround time for completion of these requests is within two to five business days upon receipt of sufficient clinical information. There are times when cases may take up to the maximum timeframe of 7 days (i.e. if additional clinical information is needed), but that is not the norm.
If the referring provider fails to obtain prior authorization for the procedure, will the member be held responsible?	This prior authorization program will not result in any additional financial responsibility for the member, assuming use of a participating provider, regardless of whether the provider obtains prior authorization for the procedure or not. The participating provider may be unable to obtain reimbursement if prior authorization is not obtained, and member responsibility will continue to be determined by plan benefits, not prior authorization. If a procedure is not prior authorized in accordance with the program and rendered: • In an outpatient setting at/by a MHS participating provider, benefits will be denied and the member will not be responsible for payment.
How do I obtain an authorization?	Authorizations may be obtained by the physical medicine practitioner via the online portal, RadMD or via phone at 1-866-904-5096. The requestor will be asked

	to provide general provider and patient information as well as some basic questions about the member's function and treatment plan. Based on the response to these questions, a set of services may be offered real-time. If we are not able to offer a real-time approval for services or the provider does not agree to accept the authorization, additional clinical information may be required to complete the review. Clinical records may be uploaded via RadMD or faxed to 1-800-784-6864 using the coversheet provided.
What information should you have available when obtaining an authorization?	• Diagnosis(es) being treated (ICD10 Code) • Requesting/Rendering Provider Type – PT, OT, ST • Date of the initial evaluation at their facility • Type of Therapy: Habilitative, Rehabilitative, Neuro Rehabilitative • Surgery date and procedure performed (if applicable) • Date the symptoms started • Planned interventions (by billable grouping category) and frequency and duration for ongoing treatment. • How many body parts are being treated and is it right or left. • The result of the Functional Outcome Tool used for the body part evaluated. The algorithm is looking for the percentage the patient is functioning with their current condition. Example: If a test rated them as having a 40% disability, then they are 60% functional. • Summary of functional deficits being addressed in therapy.
During the transition to prior authorization what documents should be submitted for a patient that was previously reviewed in the post service authorization through NIA?	When submitting documentation on a case that was previously managed by NIA, it is not necessary to resubmit all documents that you have previously sent in. You DO need to submit the most recent progress note. For Rehabilitative care the progress note should be within the past 30 days. For Habilitative Care the progress note should be within the past 90 days.
How will I confirm physical medicine benefits for a member?	Member benefits, benefit limitations and number of visits remaining for the year should be confirmed through MHS' Customer Service. Member benefits are calculated by visits per year. Each date of service is calculated as a visit.

If a provider has already obtained prior authorization and more visits are needed beyond what the initial auth contained, does the provider have to obtain a new prior authorization?	Additional services on an existing authorization should NOT be submitted as a new request. If/when an authorization is nearly exhausted, additional visits may be requested as an addendum/addition to the initial authorization. To initiate a request for additional care, providers can use the fax cover sheet from the initial authorization to submit updated clinical records, or may load these records to the existing authorization in RadMD. To obtain additional services, clinical records will be required. Providers may upload these records through RadMD or fax them to NIA at 1-800-784-6864 using the coversheet provided at the time of the initial authorization. Additional fax coversheets may also be printed from RadMD or requested via phone at 1-866-904-5096. If the member needs to be seen for a new condition, or there has been a lapse in care (more than 30 days) and care is to be resumed for a condition for which there is an expired authorization, providers should submit a new initial request through RadMD or via telephone at 1-866-904-5096.
What if I just need more time to use the services previously authorized?	A one-time 30-day date extension on the validity period of an authorization is permitted and can be requested via phone at 1-866-904-5096 or by submitting an electronic request through RadMD or fax to 1-800-784-6864 using the coversheet provided. Date extensions are subject to any benefit limits that may restrict the length of time for a given condition/episode of care. Extensions beyond the initial 30-day request or outside of any benefit constraints may require clinical records to be submitted.
If a patient is discharged from care and receives a new prescription or the validity period ends on the existing authorization, what process should be followed?	A new authorization will be required after the one-time 30 day extension or if a patient is discharged from care.
If a patient is being treated and the patient now has a new diagnosis, will a separate	If a provider is in the middle of treatment and gets a new therapy prescription for a different body part, the treating provider will perform a new evaluation on that body part and develop goals for treatment. If the two areas are to

authorization be required?	be treated concurrently, the request would be submitted as an addendum to the existing authorization, using the same process that is used for subsequent requests. NIA will review the request and can add additional visits and the appropriate ICD 10-code(s) to the existing authorization. If care is to discontinue on the previous area being treated and ongoing care will be solely focused on a new diagnosis. Providers should submit a new request for the new diagnosis and include the discharge summary for the previous area. A new authorization will be processed and the previous will be ended.
Could the program potentially delay services and inconvenience the member?	A prior authorization request can easily be initiated via RadMD or telephone at 1-866-904-5096 within a few minutes. In cases where additional clinical information is needed, a peer to peer consultation with the provider may be necessary and can be initiated by calling 1-888-642-7649. Responses to NIA requests for additional clinical information or peer to peer are needed to ensure a timely review and determination. Requests initiated via fax require clinical validation and may take additional time to process. The fax number is 1-800-784-6864.
What happens in the case of an emergency?	The NIA Website, www.RadMD.com cannot be used for medically urgent or expedited prior authorization requests. Those requests must be processed by calling the call center at 1-866-904-5096.
How are procedures that do not require prior authorization handled?	If no authorization is needed, the claims will process according to MHS' claim processing guidelines.
Appeals and Re-Review Process	
If a provider disagrees with a physical medicine determination made by NIA, is there an option to appeal the determination?	The Peer-to-Peer process can be initiated once the adverse determination has been made. In the event of any sort of adverse determination, NIA will reach out to the provider to offer a peer-to-peer discussion. After the determination has been finalized, providers may still request to discuss the case as an informal reconsideration (peer to peer / re-review) prior to requesting a formal appeal. Re-reviews on determinations must be made within ten days via a peer-to-peer discussion. The phone number to initiate a peer-to-peer is 1-888-642-7649. These discussions provide an opportunity to discuss the case and

	collaborate on the appropriate services for the patient based on the clinical information provided. In the event a provider disagrees with NIA's final determination, as a vendor for MHS, NIA will offer options for an informal reconsideration and/or an appeal. Appeal guidance is provided in the initial determination letter. Peer-to-peer consultations can be conducted anytime during normal business hours, or as required by Federal or State regulations.
Is the re-review process available for the physical medicine program once a denial is received?	A re-review (informal reconsideration) can be initiated through the peer to peer process. Once the denial determination has been made the provider will be offered a peer to peer discussion, or can call 1-888-642-7649 to initiate the peer to peer process themselves. Re-review must be initiated within ten days of a denial or before submitting an appeal for all membership.
RadMD Access	
What option should I select to receive access to initiate authorizations?	"Physical Medicine Practitioner" which will allow you access to initiate authorizations.
How do I apply for RadMD access to initiate authorization requests?	User would go to our website www.RadMD.com. • Click on NEW USER. • Choose "Physical Medicine Practitioner" from the drop down box • Complete application with necessary information. • Click on Submit Once an application is submitted, the user will receive an email from our RadMD support team within 72 hours after completing the application with their approved user name and a temporary passcode. Please contact the RadMD Support Team at 1-877-80-RadMD (1-877-807-2363) if you do not receive a response with 72 hours. Your RadMD login information should not be shared.
What is rendering provider access?	Rendering provider access allows users the ability to view all approved authorizations for their office or facility. If an office is interested in signing up for rendering access, you will need to designate an administrator. • User would go to our website www.RadMD.com

	• Select “Facility/Office where procedures are performed” • Complete application • Click on Submit Examples of a rendering facility that only need to view approved authorizations: • Hospital facility • Billing department • Offsite location • Another user in location who is not interested in initiating authorizations Once an application is submitted, the user will receive an email from our RadMD support team within 72 hours after completing the application with their approved user name and a temporary passcode. Please contact the RadMD Support Team at 1-877-80-RadMD (1-877-807-2363) if you do not receive a response with 72 hours. Your RadMD login information should not be shared.
Who can I contact if we need RadMD support?	For assistance or technical support, please contact RadMDSupport@MagellanHealth.com or call 1-877-80-RadMD (1-877-807-2363). RadMD is available 24/7, except when maintenance is performed once every other week after business hours.
Paperless Notification	
How can I receive notifications electronically instead of paper?	NIA has paperless notifications. Please follow this process if you are interested in receiving paperless notifications: 1. During each RadMD-initiated request, the user will be given the option to receive an electronic notification instead of via mail. a. Once selected, electronic notification will be used for all notifications for that authorization only. b. Each time a request is entered on RadMD, the user must choose electronic or mail notification. 2. If the user opts to receive electronic notification, an email will be sent when a determination is made. a. No PHI will be contained in the email. b. The email will contain a link that requires the user to log into RadMD to view PHI.

	3. A note is entered into the request to reflect email notification was given and to whom the email note was addressed.
Contact Information	
Who can a provider contact at NIA for more information?	If you have a question or need more information about this physical medicine prior authorization program, you may contact the NIA Provider Service Line at: 1-800-327-0641. You may also contact your dedicated NIA Provider Relations Manager: April Sabino 1-410-953-1078 AJSabino@magellanhealth.com