National Imaging Associates, Inc. (NIA)
Frequently Asked Questions (FAQ's)
For Aetna
Delaware Providers
Performing Physical Medicine Services

Question	Answer
General	
Who is National Imaging Associates, Inc. (NIA)?	NIA is a specialty healthcare management company which delivers comprehensive and innovative solutions to improve quality outcomes and optimize the cost of care.
When did the Physical Medicine Services program begin for Aetna?	Effective September 1, 2018, NIA began managing Physical Medicine Services for Aetna Delaware members.
Which Aetna Delaware members are covered under this relationship and what networks are being used?	NIA manages Physical Medicine Services for Aetna Delaware membership through Aetna Delaware contractual relationships. **Please note that this program includes Fully Insured Commercial and Medicare membership only.** Administrative Services Only (ASO)/Administrative Services Contract (ASC) Self-Funded membership is currently excluded, as well as members using out of network benefits using non-participating providers.
How can a provider confirm if a member belongs to a Self-Funded (ASO/ASC) plan which is excluded from the authorization process?	ASO/ASC (Self-Funded) membership is currently excluded from this prior-authorization program. If you are certain the member is part of Aetna and the member is not found when initiating authorizations on RadMD, then the member is not part of the NIA program and does not require prior authorization. Providers should continue to follow the current process in place today for Aetna's ASO/ASC Self-Funded membership and will continue to be subject to Aetna's post review audits for this membership.
Is prior authorization necessary for Physical Medicine Services if Aetna is NOT the member's primary insurance?	No. This program applies to members who have Aetna or Medicare Advantage as their primary insurance.

Which services are excluded from the Physical Medicine Program?	NIA will not prior authorize services performed in an Inpatient Hospital, Emergency Room, Observation Status, Inpatient Acute Rehab Hospital, Inpatient and Outpatient Skilled Nursing Facility or Home Health Therapy. The treating provider should continue to follow Aetna's policies and procedures for services performed in the above settings.
Why did Aetna implement a physical medicine utilization management program?	This physical medicine solution is designed to promote evidence based and cost effective physical therapy, occupational therapy, and chiropractic services for Aetna Delaware members.
Why focus on physical therapy, occupational therapy, and chiropractic services?	A consistent approach to applying evidence-based guidelines is necessary so Aetna Delaware members can receive high quality and cost effective physical medicine services.
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 are impacted by this physical medicine program?	Any independent providers, hospital outpatient, and multispecialty groups rendering physical therapy, occupational therapy, and/or chiropractic services as defined by the scope of codes managed in this program will need to ensure prior authorization has been granted. This program began on September 1, 2018 for all Aetna Delaware Fully Insured Commercial and Medicare 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 (one business day for urgent requests). All decisions are, at minimum, rendered within State required timelines or within 10 calendar days where not explicitly defined by the State. 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, chiropractors and board-certified physicians. Decision 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 Aetna 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 CPT code. 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. Aetna 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?	Evaluation codes including E&M codes do not require authorization. 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 to five (5) business days to request approval for the first visit. After the first visit, providers need to obtain prior authorization before each subsequent visit to ensure the services meet medical necessity criteria.

What CPT codes and procedures will require prior authorization?	A comprehensive list of the physical medicine CPT codes and procedures included in this program can be found in the Physical Medicine Utilization Review Matrix document posted on the NIA website at www.RadMD.com. Any elective procedures within this code set require prior authorization.
Will a separate authorization need to be obtained for each CPT code managed under the Physical Medicine Program?	An authorization will show the approval of a single parent code. CPT codes included in the billable groupings are considered part of that authorization. Providers are not limited to only billing the parent code; they should render and bill the CPT code that aligns to the appropriate service for that member within any approved billable grouping.
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 1-866-842-1542 to obtain authorization for physical medicine services effective September 1, 2018. Prior authorization is required for members that are currently receiving care which will extend to September 1, 2018 and beyond. NIA began accepting requests on August 27, 2018 for services that began on September 1, 2018. 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?	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 10 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 an Aetna participating provider, benefits will be denied and the member will not be responsible for payment. • During an inpatient stay at/by an Aetna participating provider, if the inpatient stay was approved, payment will be made at the preferred level of benefits. • During an inpatient stay at/by an Aetna participating provider, and the inpatient stay was not approved, benefits will be denied and the member will not be responsible for payment. • By a non-participating provider, the claim will be adjudicated at the member's out-of-network benefit, just as it is today. If the member has no out-of-network benefit, the claim will be denied with the patient responsible for the charges.
How do I obtain an authorization?	Authorizations may be obtained by the physical medicine practitioner via the online portal, RadMD or via phone at 1-866-842-1542. 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 (i.e.; units or services authorized), 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 does the authorization number contain?	Authorizations are issued at the code and unit level. An authorization contains the parent CPT code(s) that represent the billable grouping(s), a number of units for each service type/grouping, and a validity period with which these services may be rendered. Please note that while the authorization contains single CPT code(s), this is representative of a grouping of related codes that may be rendered and billed under that authorization to allow necessary flexibility in the treatment plan. The full list of codes, groupings and additional explanation is available on RadMD.

What information should you have available when obtaining an authorization?	• Diagnosis(es) being treated (ICD10 Code) • Requesting/Rendering Provider Type – PT, OT, Chiro (DC), MD, DO, Other • 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.
How should I confirm physical medicine benefits for a member?	Member benefits, benefit limitations and number of visits remaining for the year should be confirmed through Aetna's Customer Service. Member benefits are calculated by visits per year. Each date of service is calculated as a visit.
How are units managed?	NIA manages authorizations in units and follows Medicare rules for reporting timed units. The billing of these units are based on 15 minute increments for timed based codes. Authorizations include specified units based on the services requested and your patients' medical condition. Additional units can be requested by uploading supportive clinical documentation or faxing to NIA at 1-800-784-6864 using the coversheet provided.
If a provider has already obtained prior authorization and the patient needs another physical medicine service in the future, does the provider have to obtain another prior	Authorizations are issued specific to a condition and procedure (code). If/when any part of the authorization has been exhausted – additional units needed, new codes needed validity period expired or a new condition exists – additional authorization will be required. For additional services (units or service code types), a subsequent request should be submitted.

authorization or can the provider continue treatment without obtaining an additional prior authorization?	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 1-866-842-1542. 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 1-866-842-1542.
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 1-866-842-1542 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 for a services and the patient now has a new diagnosis, will a separate authorization be required?	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. NIA will review the request and additional units to support that treatment. Once the case is approved, the additional units would be added to the existing authorization with the new ICD 10 code.
Could the program potentially delay services and inconvenience the member?	A prior authorization request can easily be initiated via RadMD or telephone at 1-866-842-1542 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 cannot be used for medically urgent or expedited prior authorization requests. Those requests must be processed by calling NIA at 1-866-842-1542.
Will there be anything on the ID card to indicate that a member is included in the physical medicine program?	No. Providers should continue to verify member eligibility through Aetna and obtain prior authorization from NIA for physical medicine services for Fully Insured Commercial and Medicare members effective September 1, 2018.
How are procedures that do not require prior authorization handled?	If no authorization is needed, the claims will process according to Aetna's claim processing guidelines. You can go to www.aetna.com, click on the link for "Providers", then go to the "Quick Links" section and click on "Precertification". From there you can "Search by CPT code" to determine the codes requiring an authorization.
Appeals and Reconsiderations 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 determination has been made. The phone number to initiate this option is 1-888-642-7649. This is 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, Aetna offers options to 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 reconsideration process available for the physical medicine program once a denial is received?	A reconsideration can be initiated in one of two ways: 1. Peer to peer discussion 2. Submitting additional clinical information Reconsideration must be initiated within 14 calendar days of a denial or before submitting an appeal for all membership with the exception of Medicare membership.

How does the prior authorization process differ for non-participating providers?	No prior authorization is required for non-participating providers.
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?	Aetna Delaware providers can contact their dedicated NIA Provider Relations Manager: Charmaine Gaymon Everett 1-800-450-7281, ext. 32615 cseverett@magellanhealth.com NIA Customer Care Associates are available to assist providers at 1-866-842-1542.