National Imaging Associates, Inc. (NIA)
Frequently Asked Questions (FAQ's)
For Aetna
Pennsylvania 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?	This program was effective September 1, 2018 for all Aetna Pennsylvania fully insured commercial and Medicare membership.
When does the change to total number of units per authorization period occur and how will it impact providers?	Beginning on November 9, 2020, providers will request authorizations for services based on the total number of units per authorization period, rather than by specific interventions. This eliminates the need to pre-determine and track units into separate categories based on the specific interventions provided. Authorizations will be inclusive of all managed CPT codes that pertain to the respective treating discipline. This change simplifies the authorization process and allows necessary flexibility in providers' treatment plans.
Which Aetna Pennsylvania members will be covered under this relationship and what networks will be used?	NIA will manage Physical Medicine Services for Aetna Pennsylvania membership through Aetna Pennsylvania 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, the member is part of the ASO/ASC (Self-Funded) plan 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 is Aetna 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 chiropractic services for Aetna Pennsylvania members.
Why focus on physical therapy, occupational therapy, and chiropractic services?	A consistent approach to applying evidence-based guidelines is necessary so Aetna Pennsylvania 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 will potentially be 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.
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.
Who is responsible for obtaining prior authorization of the procedure?	The physical medicine practitioner/facility is responsible for obtaining prior authorization for Physical Medicine 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. Determination 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.

If I perform treatment on the day of the evaluation do I need an authorization and how many days do I have to submit my request?	Providers will have up to 14 calendar days to request approval for treatment provided during the initial visit. If requested 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. If treatment is not performed on the day of the initial evaluation, an approved authorization is required prior to the first treatment session or the claim may be denied.
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 www.RadMD.com, under the "Health Plan Educational Docs" heading. 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?	No, providers will request an authorization for services based on the total number of units, rather than by specific interventions. Authorizations will be inclusive of all managed CPT codes that pertain to the respective treating discipline.
What kind of response time can providers expect for prior authorization of physical medicine requests?	NIA leverages a clinical algorithm to assist in making real time decisions at the time of the request based on the requestors' answers to clinically based questions. If we cannot offer immediate approval, generally the turnaround time for completion of these requests is within 2 - 3 business days upon receipt of sufficient clinical information. There are times when cases may take longer if additional information is needed.
Who is the "Ordering/ Treating Provider" and "Facility/Clinic?"	The ordering/treating provider is the therapist who is treating the member and is performing the initial therapy evaluation. The facility/clinic should be the primary location where the member is receiving care. You will be required to list both the treating provider and the rendering facility when entering the prior authorization request in RadMD. If you are not utilizing RadMD, please have the information available at the time you are initiating your request through the Call Center.
Can multiple providers render physical medicine services to members if	Yes, the authorization is linked between the members ID number and the facility's TIN. So long as the providers work under the same TIN and are of the same

their name is not on the authorization?	discipline, they can use the same authorization to treat the member.
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 www.RadMD.com (preferred method) or if unable to utilize RadMD, may call: 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.

How do I send clinical information to NIA if it is required?	The most efficient way to send required clinical information is to upload your documents to RadMD (preferred method). The upload feature allows clinical information to be uploaded directly after completing an authorization request. Utilizing the upload feature expedites your request since it is automatically attached and forwarded to our clinicians for review. If uploading is not an option for your practice, you may fax utilizing the NIA specific fax coversheet. To ensure prompt receipt of your information: • Use the NIA fax coversheet as the first page of your clinical fax submission. *Please do not use your own fax coversheet, since it will not contain the case specific information needed to process the case • Make sure the tracking number on the fax coversheet matches the tracking number for your request • Send each case separate with its own fax coversheet • Physical Medicine Practitioners may print the fax coversheet from www.RadMD.com or contact NIA at 1-866-842-1542 to request a fax coversheet online or during the initial phone call • NIA may fax this coversheet to the Physical Medicine Practitioner during authorization intake or at any time during the review process. **Using an incorrect fax coversheet may delay a response to an authorization request.*
What will the authorization contain?	Authorizations will contain the authorization number, total number of units for the select treating discipline (i.e. Physical Therapy, Occupational Therapy, Chiropractic Services, or other providers), and validity period with which these services may be rendered. Full details of the program and scope limitations can be found in the “Health Plan Specific Educational Docs” section of RadMD.com under Aetna.
What information should you have available when obtaining an authorization?	• Member name / DOB • Member ID • 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) • Symptom start date • Planned interventions 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/standardized outcome measure 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.
How will I confirm physical medicine benefits for a member?	Member benefits and benefit limitations should be confirmed through Aetna's Customer Service. Member's benefits are calculated by visits per year. Each date of service is calculated as a visit.
How should units be managed?	NIA will manage 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. A maximum of 4 units may be charged for a single date of service. Providers will request authorization for services based on total number of units for the select treating discipline (i.e. Physical Therapy, Occupational Therapy, Chiropractic Services, or other providers), rather than by specific interventions. Additional units can be requested by uploading supportive clinical documentation to RadMD or faxing to NIA at 1-800-784-6864 using the provided NIA coversheet.
If a provider has already obtained prior authorization and the patient needs another physical medicine service	Additional services on an existing authorization should NOT be submitted as a new request. If/when an authorization is nearly exhausted, additional units may be requested as a subsequent request to the initial authorization.

in the future, does the provider have to obtain another prior 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 provided NIA coversheet. 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 30-day date extension on the validity period of an authorization is permitted and can be requested by utilizing the "Request Validity Date Extension" option on RadMD. Date extensions are subject to any benefit limits that may restrict the length of time for a given condition/episode of care.
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 authorization expires or if a patient is discharged from care.
If a patient is being treated and the patient 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. • If the two areas are to 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 units 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 one will be discontinued.

Could the program potentially delay services and inconvenience the member?	We will make every attempt to process authorization requests timely and efficiently upon receiving a request from a provider. We recommend utilizing www.RadMD.com as the preferred method for submitting prior authorization requests. If your request cannot be initiated through our portal, you may initiate a request by calling: 1-866-842-1542. In cases that cannot be immediately approved and 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. 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 during business hours. Those requests must be processed by calling the NIA call center 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.
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, Reconsiderations, and Re-open 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. This is an opportunity to discuss the case and collaborate on the appropriate services for the patient based on the clinical information provided. Peer-to-peer consultations can be conducted anytime during normal business hours, or as required by Federal or State regulations. The phone number to initiate this option is 1-888-642-7649. Reconsiderations are available if providers would like to submit additional clinical documentation to support their

	request and desired treatment plan. A reconsideration can be initiated through a peer-to-peer discussion or by submitting additional clinical information. The request must be initiated within 14 calendar days of a denial or before submitting an appeal for all membership with the exception of Medicare membership. Medicare re-opens are allowed for partially approved/partially denied physical medicine cases for an unlimited timeframe. Medicare re-opens are not allowed for full denials. 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.
Who should a provider contact if they want to appeal a prior authorization decision?	Providers are asked to please follow the appeal instructions given on their non-authorization letter or Explanation of Benefits (EOB) notification.
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 dropdown 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 username 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.
How can providers check the status of an authorization request?	Providers can check on the status of an authorization by using the "View Request Status" link on RadMD's main menu.

How can I confirm what clinical information has been uploaded or faxed to NIA?	Clinical Information that has been received via upload or fax can be viewed by selecting the member on the View Request Status link from the main menu. On the bottom of the "Request Verification Detail" page, select the appropriate link for the upload or fax.
Where can providers find their case-specific communication from NIA?	Links to case-specific communication to include requests for additional information and determination letters can be found via the View Request Status link.
What will the authorization number look like?	The authorization number consists of at least 11 alpha-numeric characters (i.e., 12345AEN123). In some cases, the ordering provider may instead receive a tracking number (i.e., 123456789) if the provider's authorization request is not approved at the time of initial contact. Providers will be able to use either number to track the status of their request online or through an Interactive Voice Response (IVR) telephone system.
If I did not submit the initial authorization request, how can I view the status of a case or upload clinical documentation?	The "Track an Authorization" feature will allow users who did not submit the original request to view the status of an authorization, as well as upload clinical information. This option is also available as a part of your main menu options using the "Search by Tracking Number" feature. A tracking number is required with this feature.
Can I share my RadMD access with my co-workers?	Yes, through our shared access process. This process allows providers to view authorization requests initiated by other RadMD users within your practice. By sharing access with other users, the user will be able to view and manage the authorization requests that you initiated, allowing them to communicate with your patients and progress with treatment if you are not available.
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 Notifications	
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 Pennsylvania providers can contact: • Provider Service Line (PSL) 1-800-327-0641 • NIA Provider Relations Manager: Seth Cohen PT, DPT 1-800-450-7281, ext. 32418 cohens@magellanhealth.com