# National Imaging Associates, Inc. (NIA)[1]

# Imaging Provider Handbook

[1] *National Imaging Associates, Inc. (NIA) is an affiliate of Magellan Healthcare, Inc.*

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# Welcome to the NIA Provider Handbook!

This provider handbook is your reference guide for navigating radiology and medical specialty benefits management with NIA. As a contracted NIA provider of clinical care, it is your responsibility to be familiar with and adhere to the policies and procedures outlined in this handbook. Each section of the handbook contains our philosophy, our policies, your responsibilities to us and our responsibilities to you. The handbook is designed to give you a helpful overview of your role as a network provider/facility with NIA; details about our credentialing, privileging and contracting policies; information about the NIA prior authorization process; and a summary of our quality improvement program.

This handbook also provides information about rendering provider or facility self-service features available to you on our website at www.RadMD.com. RadMD offers rendering providers or facilities a wealth of powerful resources and tools including the ability to request authorizations on behalf of the ordering physician with a rendering login, view approved requests, clinical guidelines and more.

To get started, each rendering provider/ facility (based on facility location or Tax ID number) will designate an Administrator for the RadMD account. The Administrator may sign into NIA's website by going to www.RadMD.com, click the New User button on the right side of the page and set up a unique username/account ID and password. Once the Administrator obtains access to RadMD, this person must accept responsibility for creating and managing all other logins that will be used by employees of that group or facility. Once the Administrator creates an account for other users within the facility, each user can enter their username and password to access information using RadMD.

## About NIA

NIA has provided industry-leading specialty healthcare management services to improve health care quality and affordability for our health plan customers since 1996. Our clinical expertise, combined with data analytics, innovative technologies and operational excellence make us the partner of choice in solving challenges across the health care spectrum. NIA is dedicated to improving the quality of patient care through clinically appropriate and cost-effective use of key procedures. We achieve improved patient care in a physician-supportive, patient-centric manner that also enhances the financial performance of our customer organizations.

**NIA's Full-Service Solutions:**

- **Advanced Diagnostic Imaging:**
  - Offers prior authorization of MR, CT and PET modalities, as well as certain primary imaging procedures such as vascular and general ultrasound.
- **Cardiac Solution:**
  - Manages a broad spectrum of cardiac procedures including:
    - **Diagnostic cardiac procedures:**
      - Nuclear stress/MPI
      - Stress Echo
      - ECG stress test
      - Cardiac CT, MR and PET

        - Echocardiography (TTE/TEE)
        - Cardiac Catheterization
        - CCTA
    - **Interventional cardiac procedures:**
        - Percutaneous coronary intervention
        - Defibrillator
        - Pacemaker

- **Radiation Oncology Solution:**
    - Promotes the most clinically appropriate approach for each patient during the course of radiation therapy with the expertise of our clinical team and our comprehensive, evidence-based guidelines.

- **Musculoskeletal Management (MSK) Solution:**
    - Manages both surgical and non-surgical musculoskeletal care including spine and large joints.
- **Interventional Pain Management Solution:**
    - Ensures the appropriateness of pain management procedures

- **Physical Medicine Solution:**
    - Manages chiropractic as well as physical, occupational and speech therapy (Rehabilitative and Habilitative therapy) to ensure appropriate care, while also maintaining proper frequency and duration of care and coordination among all available services.

- **Accountable Care Organization (ACO) Solution:**
    - Proprietary Clinical Decision Support (CDS):
        - Offers a simple, web-based application with clinically accepted protocols and objective educational guidance.

Some of the services above are delivered in collaboration with a health plan's own provider network.

# The Provider Partnership: What it means to be an NIA Provider

NIA's emphasis is on working in partnership with network providers/facilities (referred to herein as "rendering providers," "facilities," "imaging providers" or "imaging facilities") to deliver optimal health outcomes to members. NIA shares the following objectives with our network providers:

- Delivering the right procedure at the right time for members.
- Limiting patients' exposure to unnecessary and harmful iodizing radiation.
- Reducing "false positives" or misinterpreted results that could lead to unnecessary additional procedures, e.g., surgeries and additional time and financial burdens on patients.

For referring providers, NIA strives to provide the finest clinically-supported consultation process possible; to deliver consultation as quickly as possible with the least infringement on providers' workflow; and to provide complete transparency as to the rationale for all consultations.

We then work with our imaging facility providers to help members obtain appropriate, affordable diagnostic imaging services. By working closely with you—our contracted imaging facility—and incorporating your updated capabilities and quality results into our service database, we can help ensure that members have access to high quality diagnostic imaging resources.

We make available a host of provider services tools on our website to help you obtain the information and assistance you need. All these systems are designed to work together to support your radiology business practices.

NIA appreciates your commitment to providing quality, affordable diagnostic imaging services to members, and we look forward to working with you!

# Provider Assessment

**Our Philosophy**

NIA is committed to the provision of quality care to our members. In support of this commitment, NIA conducts a provider assessment process whereby providers/facilities must meet a set of credentialing criteria and privileging standards to be eligible to provide select services to our membership.

**Our Policy**

**Provider assessment encompasses both credentialing and privileging.** NIA employs credentialing criteria and decision-making processes in the review and selection of imaging providers for inclusion in our provider network. Our imaging facility credentialing criteria satisfy the requirements of applicable accreditation and regulatory bodies, in addition to those of our customers.

NIA's privileging program policies establish reasonable and consistent standards for the performance of all diagnostic imaging services. The program establishes minimum participation guidelines that include facility accreditation, equipment capabilities, physician and technologist education, training and certification, documented procedures for handling patient emergencies, ACLS, ARLS or BLS certified physician supervision on-site during contrast enhanced procedures (when using teleradiology, the radiologists performing the imaging

services must be on-site during normal business hours), and facility management components such as radiation safety guidelines (e.g. ALARA —As Low as Reasonably Achievable). These guidelines are established and refined with consideration of the American College of Radiology (ACR) and other accreditation bodies, diagnostic imaging common practice standards, updated literature reviews and new technology assessments. NIA provides ongoing monitoring of imaging practices and facilities.

**Provider/Facility Responsibility**

Complete the online NIA Diagnostic Imaging Provider Assessment Application on RadMD.com. The online tool has intuitive user interface capability and is very easy to use. Submit all required documents, including certification and insurance. You will also be required to include information on current accreditation and licensure. Incomplete applications will not be processed.

The **credentialing portion** requires that you:

- Be in good standing with state and federal regulatory entities, as applicable.
- Hold current licensure or certification without contingencies or provisions, in accordance with applicable state and federal laws.
- Not be debarred, suspended, sanctioned, terminated, precluded, or otherwise excluded under the HHS/OIG List of Excluded Individuals and Entities ("LEIE List"), the U.S. General Services Administration's (GSA) web-based System Award Management (SAM) Exclusion Database, the CMS Preclusion List, and other applicable federal and state exclusion/termination/suspension/sanction lists in any state, including, but not limited to, where services are rendered or delivered.
- Hold current applicable licensure for radiology equipment and materials.
- Ensure staff radiologists/technicians hold appropriate license and/or certification.
- Comply with NIA requirements for professional liability claims history review.
- Meet NIA's minimum requirements for professional and general liability insurance coverage as outlined in your Participating Imaging Facility Agreement.
- Conduct Primary Source Verification (PSV) of the credentials of other medical and clinical staff members, as required. See Appendix A for compliance with Radiologist Quality Requirements.
- Participate in additional assessment activities, such as record or image review or on-site visit, if requested.
- Participate in re-credentialing every three years or in compliance with regulatory and/or customer requirements.
- Complete the Medicaid Disclosure Form (MDF) if Facility renders services to the Medicaid Population.

The **privileging portion** requires that you:

- Comply with diagnostic imaging equipment standards (e.g. minimum MR Tesla strengths, CT slices, etc.).
- Utilize appropriately certified technologists.

- Maintain accreditation by the American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC) or RadSite for all modalities performed, as appropriate.
- Maintain appropriate imaging policies and procedures (e.g. Radiation Safety, ALARA, etc.).

**NIA's Responsibility**

- Direct you to www.RadMD.com to complete the Diagnostic Imaging Provider Assessment (credentialing and privileging) Application and MDF, if necessary.
- Review your completed Provider Assessment Application and notify you in writing once a final determination has been rendered by the Regional Network and Credentialing Committee (RNCC).
- Provide Privileging Guidelines on www.RadMD.com, under Handbook/Policies: Privileging Guidelines. You must have a login in order to view these.

# Contracting

**Our Philosophy**

NIA believes that a legally binding document with our providers serves to clearly outline covered services available to NIA members, as well as expectations regarding NIA's policies, procedures, provider reimbursement, and the terms and conditions of participation as a network provider.

**Our Policy**

Imaging providers and facilities must have an executed participation agreement with NIA (or such entity to which NIA may delegate contracting) whereby the provider or facility agrees to comply with NIA's policies, procedures and guidelines and accepts referrals and reimbursement for covered services rendered to members of NIA's customers.

**Provider/Facility Responsibility**

- Review, understand and comply with your obligations under your participation agreement with NIA (or such entity to which NIA may delegate contracting). If the terms of your agreement differ from the terms contained in this Imaging Provider Handbook, the terms of your agreement supersede.
- Successfully complete the provider assessment (privileging and credentialing) process.
- Be familiar with the policies and procedures contained within this NIA Imaging Provider Handbook and any applicable state- and customer-specific Quick Reference Guides, supplements, and benefit plan schedules.

**NIA's Responsibility**

- Provide an NIA Participating Imaging Facility Agreement to your facility when it has been identified for participation in the NIA provider network.
- Execute the agreement after your facility has successfully completed the provider assessment process and been approved by the Regional Network and Credentialing Committee (RNCC). Provide the fully executed agreement, signed by both parties, for your records.
- Include all applicable reimbursement schedules as exhibits to your contract.
- Operate a Facility Site Selection (FSS) program, if applicable. This program is designed to assist ordering providers and members to identify the most conveniently located participating providers.

# Communicating with NIA

**Our Philosophy**

Our providers need access to pertinent information in order to serve our members effectively and to address issues related to policies and procedural requirements. NIA must keep information about our providers up to date to facilitate authorizations and claims payment.

**Our Policy**

NIA utilizes a variety of methods to communicate with our providers about policies, procedures, and expectations, including but not limited to the RadMD.com Website, the national NIA Imaging Provider Handbook, handbook supplements and Quick Reference Guides. The day-to-day relationship between NIA and our providers is managed through Provider Network and Clinical Management staff located in our call centers. NIA strives to maintain accurate information about providers in our data systems.

**Provider/Facility Responsibility**

- Familiarize yourself with the information in your participation agreement and in this Imaging Provider Handbook and any applicable state and customer-specific supplements.
- Use the RadMD.com Website to obtain updated information about your exam request authorizations, review NIA guidelines and check for periodic updates to policies and procedures, and to access radiology network news.
- Obtain assistance with benefit eligibility: Contact the member's health plan by calling the number on the back of the member's health benefit card.
- Notify NIA of changes in services performed at any location or demographic information, including but not limited to changes in facility ownership (Taxpayer Identification number (TIN), and/or National Provider Identifier (NPI), name, address, or telephone number, as well as the ability to accept referrals, including any site closure). Submit changes to your Area Contract Manager: You may call, email or mail written changes to:

  NIA – Provider Service Line (PSL) MO61
  14100 Magellan Plaza
  Maryland Heights, MO 63043
  Phone number: 800-327-0614
  Wendy Hirn: wjhirn@magellanhealth.com
  Debbie Patterson: dlpatterson@magellanhealth.com

**NIA's Responsibility**

- Provide a single point of contact. Each provider is assigned a Contract Manager for credentialing, contracting and communicating changes made to your site's services. You will also be assigned a Provider Relations Manager to educate your staff on NIA procedures and assist you with any provider issues or concerns.

- Offer assistance regarding benefit eligibility through the available member services number on the member's card.
- Offer assistance regarding provider assessment, contracting and program/practice changes through our national toll-free Provider Services Line at 1-800-327-0641.
- Communicate information about policies, procedures and expectations in a timely manner.
- Post policies and procedures on RadMD for reference.
- Update provider records accurately and in a timely manner, verifying changes with the provider.

## Appeals and Complaints

We are committed to maintaining strong, mutually rewarding relationships with our providers. Sometimes, there may be differences of opinion, interpretation or understanding that cannot be avoided. NIA wants to receive appeals or complaints as soon as possible, so that we may address them in a timely manner. The following are the appropriate contacts for appeals and complaints:

- Network Participation Contracting: NIA maintains a network that is of an appropriate size to meet the needs of covered members in each area. We may choose to restrict network size based on member enrollment. If you believe that you have been excluded from the provider network inappropriately, please contact your NIA Contracts Manager or the Provider Services Line at 1-800-327-0641.
- Network Participation Provider Assessment: NIA follows provider assessment criteria to assess providers' suitability for network participation. On occasion, providers have credentials that may not meet criteria. To appeal NIA's provider assessment decision, please send your appeal to:

  NIA- Radiology Network Services Appeals
  MO61
  14100 Magellan Plaza
  Maryland Heights, MO 63043.

Providers have a set timeframe in which to appeal based on statutes and customer/plan criteria. Please follow the instructions on the letter carefully in order to appeal a decision.

# Authorization

**Our Philosophy**

NIA defines medically necessary services as those that are 1) essential for the efficient diagnosis of a member's specific medical condition, 2) appropriate to the symptoms presented, 3) within generally accepted standards of practice, 4) not primarily for the convenience of the member, the member's physician or other providers, 5) performed in the most cost-effective setting and manner available, and 6) delivered in a manner that protects member safety.

To provide guidance in this regard, NIA publishes up-to-date written clinical guidelines covering the common reasons for requesting imaging studies. These guidelines have been developed from practice experience, literature reviews, specialty criteria sets, and empirical data. The NIA clinical guidelines are regularly updated and can be accessed at www.RadMD.com.

As part of NIA's ongoing quality monitoring and patient safety initiatives, NIA also includes a radiation awareness component with notification to ensure that providers are aware of frequent testing on their patients and can make decisions about whether they believe the test they are requesting is appropriate or if another diagnostic tool is more appropriate as a result of the given circumstance.

**Our Policy**

Certain advanced diagnostic imaging services provided to members must be authorized by NIA prior to or at the time of service, in accordance with NIA and customers' policies and procedures. NIA's policy indicates that ordering providers are responsible for obtaining authorization from NIA prior to referring members to imaging facilities.

Rendering Providers may initiate authorizations on behalf of the ordering provider only via www.RadMD.com and using Rendering Provider Access. For Clinically Urgent/Expedited requests, Imaging Facility will refer to the Health Plan specific Quick Reference Guide for the Call Center Numbers to initiate the authorization.

NIA's authorization-of-care decisions are based on clinical information relevant to the type and level of service being requested, utilizing NIA's or customer-specific medical necessity criteria, medical policy or diagnostic imaging guidelines for pre-authorization.

Please note: Procedures performed that have not been properly authorized will not be reimbursed, and the member cannot be balance-billed.

### Procedures Requiring Prior Authorization

Generally, the following outpatient non-emergent procedural categories require prior authorization; specific modalities requiring prior authorization will vary by payor and are summarized in supplemental provider communications. **A separate authorization number is required for each procedure ordered.*

- CT/CTA
- CCTA
- MRI/MRA

- PET Scan
- Diagnostic Nuclear Medicine
- Myocardial Perfusion Imaging
- MUGA Scans
- Stress Echo
- Echocardiography (TTE/TEE)
- Cardiac Catheterizations
- Radiation Oncology
- Musculoskeletal Management
    - (Spine Surgery/IPM)
- Physical Medicine
    - (Chiropractic Care, Speech, Physical and Occupational Therapies)

*Modalities requiring prior authorization depend upon the payor and may include additional modalities not listed above. Providers may verify specific payor authorization guidelines by logging on to www.RadMD.com prior to rendering services.

**Imaging services rendered in an Emergency Room, Observation Room, Surgery Center or Hospital Inpatient settings are not managed by NIA. In some instances, Urgent Care may be covered. Please check with the payor.**

### Reviews After Services Have Been Rendered

Review of already completed procedures occurs on a customer-specific basis and if mandated timelines for submission have been met. Requests from NIA contracted providers are evaluated to determine whether there was an urgent or emergent situation that prohibited the provider from obtaining pre-authorization for the service. When permitted, claim dispute review requests from non-contracted providers are reviewed to determine whether medical necessity criteria were met. In all cases, if the service was authorized following the review, the claim is paid. If the service is denied, a non-authorization letter is sent to the rendering provider.

**Provider/Facility Responsibility**

As a provider of diagnostic imaging services that requires prior authorization, it is essential that you develop a process to ensure that the appropriate authorization number(s) has been obtained. The following recommendations should be considered:

- Communicate to all personnel involved in outpatient scheduling that prior authorization is required for the above procedures.
- If a physician office calls to schedule a patient for a procedure requiring prior authorization, request the authorization number.
- If a prior authorization is not in place, inform them of this requirement and advise them to call their customer-specific NIA toll-free number. As a rendering provider, you may initiate the authorization on their behalf via www.RadMD.com.
- To access the client-specific toll-free phone numbers, log into RadMD. Upon successful login, you will be on the My Practice page: Click on Authorization Call Center Phone Numbers. This will provide access to all our client-specific NIA

phone numbers for prior authorization requests that are urgent or emergent in nature. All other requests must be initiated via RadMD.com.

- If a patient calls to schedule an appointment for a procedure that requires authorization but does not have the authorization number, you may direct him or her back to the ordering physician or initiate the authorization on behalf of the ordering physician with your rendering login.

To further comply with this policy, your responsibility is to:

- Check on the status of existing authorization for the ordered diagnostic imaging service(s).
- If rendering provider is initiating the authorization, ensure both physician order and clinical documentation are uploaded via www.RadMD.com.
- When applicable, communicate the authorization decision to the member.
- Contact NIA if additional prior authorization is needed in conjunction with the current authorization.
- Not bill a member for services that have not been authorized by NIA, unless the member is informed that services will not be covered and the member agrees to such services in writing, in accordance with your Participating Imaging Facility Agreement.

**NIA's Responsibility**

- Provide fair review of the information received.
- Notify you of the decision.
- Inform you of your appeal and peer review rights and process.

# Eligibility

**Our Philosophy**

Our philosophy is to work with our customer health plans' benefit structure to meet the needs of the customer's eligible members. We rely on our customers to notify us of member eligibility.

**Our Policy**

Based on the member's benefit plan and eligibility information provided by our customers, we assist providers in determining member eligibility. The imaging provider/facility is responsible for ensuring member eligibility on the date of service.

**Provider/Facility Responsibility**

- Require a health benefit plan card from the member at the time of the procedure and copy both sides of the card for the member's file. Determine if prior authorization is required by examining the member's benefit plan card.
- If prior authorization is required, verify that the authorization has been completed on www.RadMD.com.
- Document the authorization number listed on www.RadMD.com.
- If a current authorization is required and cannot be located on www.RadMD.com, contact the ordering provider to advise that prior authorization needs to be obtained and have the ordering provider (or their staff) call NIA to request an initial authorization.
- If there has been a gap between authorization date and service date, you can document the member's eligibility by verifying it again with the health plan.

**NIA's Responsibility**

Ensure ease of access to our authorization process following your confirmation of member eligibility.
Confirm the status of an existing authorization.

# Appeals

| | |
|---|---|
| **Our Philosophy** | NIA supports the right of members or their providers (on the member's behalf) to appeal a non-authorization determination, sometimes referred to as an adverse benefit determination or unfavorable benefit determination, as the result of a claim denial. |
| **Our Policy** | Customer requirements, applicable state and federal laws, and accreditation standards govern NIA appeal policies. Therefore, the procedure for appealing benefit determinations is outlined fully in the determination correspondence that is sent to you. |
| **Provider/Facility Responsibility** | • Review the non-authorization letter or Explanation of Benefit (EOB)/Explanation of Payment (EOP) notification for:<br>  ○ The specific reason(s) for the adverse determination.<br>  ○ Appeal rights, including your right to dispute a determination on your own behalf.<br>  ○ Appeal procedures and submission timeframe.<br>  ○ Any specific documents required for submission in order to complete a review of your appeal.<br>• Follow the process described in the non-authorization letter or EOB/EOP determination notice to submit an appeal.<br>• Submit all the appeal information in a timely manner. |
| **NIA's Responsibility** | • Inform you in writing, in a clear and understandable manner, the specific reasons for the adverse determination.<br>• Inform you of options available to you after you have received an unfavorable benefit determination. Identify the appeal rights afforded to the member.<br>• Thoroughly review all information submitted for an appeal.<br>• Respond to appeal requests in a timely manner. |

# Patient Access

The rendering provider shall provide Covered Services within the timeframes provided in payor's policies and procedures.

# Member Rights and Responsibilities

**Our Philosophy**

NIA protects the rights and responsibilities of all members. We are committed to having everyone involved in the delivery of care and respect the dignity, worth, and privacy of each member.

**Our Policy**

We have established member rights and responsibilities that promote effective radiology service delivery, member satisfaction, and that reflect the dignity, worth, and privacy needs of each member. We recommend that you post the Member Rights and Responsibilities Policy in your office and ensure that they are made available to members at the time of their first appointment.

### Members' Rights

Members have the right to:

1. Receive information about our company, its services, its practitioners and providers, and member rights and responsibilities.
2. Be treated with respect and recognition of their dignity and right to privacy.
3. Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
4. A candid discussion of appropriate or medically necessary diagnostic testing options for their conditions, regardless of cost or benefit coverage.
5. Participate with practitioners in making decisions about their health care.
6. Provide input on our company's Member Rights and Responsibilities Policy.
7. Voice complaints or appeals about our company or the services it provides.
8. Receive information in a language they can understand.

### Members' Responsibilities

Members have the responsibility to:

1. Treat providers rendering health care services with dignity and respect.
2. Supply information, to the extent possible, that our company as well as providers need to deliver services.
3. Understand their health problems, including asking questions about their health care, and participate in developing mutually agreed-upon health care treatment goals to the degree possible.
4. Follow treatment plans and instructions, including scheduled appointments for service, for care upon which they have agreed with their practitioner.
5. Let their provider know about problems with paying fees.
6. Report abuse, fraud and potential quality of care issues.

**Provider/Facility Responsibility**

- Review the NIA Member Rights and Responsibilities with the member.
- Give members the opportunity to discuss their rights and responsibilities with you.
- Review with the members in your care information such as:
  - Procedures to follow if a clinical emergency occurs.
  - Fees and payments.
  - Confidentiality scope and limits.
  - The member complaint process.

- Treatment options and medication.

**NIA's Responsibility**

- The NIA Member Rights and Responsibilities Policy will be made available to network imaging providers, so they may share them with members.

## Quality Assessment Activities

**Our Philosophy**

NIA believes that assessment and review activities are integral components of its quality program. Quality review activities are used:

- As a quality assessment tool for providers in our network.
- To communicate performance expectations and standards to providers.
- To promote compliance with standards of accrediting organizations and regulatory bodies.

**Our Policy**

NIA conducts quality assessment activities with its network providers/facilities to:

- Support quality improvement initiatives.
- Evaluate provider clinical practices against guidelines or standards.
- Review potential quality of care concerns.
- Assess non-accredited providers against NIA standards.*

NIA's quality assessment includes activities such as image reviews, record reviews and on-site visits.

*** Acceptable recognized accreditation for providers includes: Accreditation for MR and CT by the American College of Radiology (ACR), the Intersocietal Accreditation Commission (ICAMRL, ICACTL) or RadSite; accreditation for PET and Nuclear Medicine by the ACR, ICANL or RadSite; accreditation for Nuclear Cardiology by the ACR or ICANL; accreditation for Peripheral Vascular Ultrasound by the ACR or ICAVL; accreditation for Echocardiography by ICAEL; accreditation for Ob/Gyn Ultrasound by the ACR or AIUM; and accreditation for General Ultrasound by the ACR or AIUM.**

**Provider/Facility Responsibility**

- Cooperate fully with the NIA quality assessment activities and staff conducting such activities.
- Facilitate an on-site review, if requested.
- Provide all required documents, including requested policies, procedures and other materials.
- Make available any requested records, images or reports.

**NIA's Responsibility**

- Conduct quality assessment and review activities, as indicated above.

Provide timely, written communication regarding results, including a description of strengths and opportunities for improvement noted by the reviewer.

# Inquiry and Review Process

**Our Philosophy**

NIA is committed to developing and maintaining a high-quality provider network.

**Our Policy**

NIA maintains a process for inquiry, review and action when concerns regarding provider performance are identified.

**Provider/Facility Responsibility**

- Actively participate and cooperate with the investigation and resolution of any identified concerns as a condition of continued participation in the Magellan provider network.

**NIA's Responsibility**

- Contact you by phone or in writing to inquire about the nature of the concern and request additional information if a concern regarding quality of care or service is raised;
- Advise you if an on-site review, treatment record review and/or other type of review is required;
- Review all inquiries for adequate resolution of any performance concerns;
- Advise you when a corrective action plan and follow-up are required;
- Advise you of a change in the conditions of your network participation, if determined to be required;
- Advise you, in writing, if any action is taken as a result of the inquiry and review process; and
- Advise you of your right to appeal if the decision to terminate your participation in the provider network is due to quality of care or service issues. The procedure for appeals is included in written notification of such a determination and includes submission of any appeal request and any additional information not previously presented, in writing, within 33 calendar days of the mailing of the determination. Appeals are heard by the members of the National Network and Credentialing Committee (NNCC) Appeals Subcommittee. Written notification of the subcommittee's determination of the appeal includes the specific reasons for the decision.

# Appealing Decisions That Affect Network Participation Status

**Our Philosophy**

Participating providers have a right to appeal Magellan quality review actions that are based on issues of quality of care or service that impact the conditions of the provider's participation in the network. Customer requirements and applicable federal and state laws may impact the appeals process; therefore, we outline the process for appealing in the written

notification that details the changes in the conditions of a provider's participation due to issues of quality of care or services.

**Our Policy**

*NIA offers participating providers an opportunity for a formal appeal hearing when NIA takes action to terminate network participation due to quality concerns.* Providers receive notice in writing of the action. Notification includes: the reason(s) for the action, the right to request an appeal, the process to initiate a request for appeal, summary of the appeal process, and that such request must be made within 33 calendar days from the date of NIA's written notification. Providers may participate in the appeal hearing either telephonically or in-person and may be represented by an attorney or another person of the provider's choice. Providers are notified in writing of the appeal decision within 30 calendar days of completion of the formal appeal hearing. Specifics of the appeal and notification processes are subject to customer, state or federal requirements.

*Professional providers whose network participation is terminated due to license sanctions or disciplinary action, or exclusion from participation in Medicare, Medicaid or other federal healthcare programs, or appearance on CMS Preclusion List are offered an internal administrative review only unless otherwise required by customer, state or federal requirements.* Providers are notified in writing of their network participation status, reason for denial of ongoing participation, and informed of their right to an internal administrative review. Providers are permitted no more than 33 calendar days from the date of NIA's written notification to request an administrative review if they disagree with the reasons for the termination. The provider is notified in writing of the outcome within 30 calendar days of the administrative review.

**Provider/Facility Responsibility**

- Follow the instructions outlined in the notification letter if you wish to appeal a change in the conditions of your participation based on a quality review determination.

**NIA's Responsibility**

Notify you in a timely manner of the determination that the condition of your participation is changed due to issues of quality of care or service;

- Consider any appeals submitted in accordance with the instructions outlined in the notification letter, subject to applicable accreditation and/or federal or state law; and
- Notify you in writing of the appeal decision within 30 calendar days of completion of the formal appeal hearing.

# Provider Satisfaction

**Our Philosophy**

Provider satisfaction is one of our core performance measures. Obtaining provider input is an essential component of our quality program and our relationship with you.

Your feedback is important to us. First, we ask that you complete the Provider Satisfaction survey so that we may identify opportunities for improvement with our policies and procedures. Additionally, to further capture your input, interviews and/or responses to brief questionnaires may be requested after contacts with customer service staff, NIA's website (RadMD), training meetings, etc. via phone, fax, mail or email.

**Our Policy**

Annually, we survey ordering providers and our contracted rendering providers.

We survey ordering providers to:

- Assess their experiences in using our pre-authorization processes.
- Assess satisfaction with our utilization management decisions and support services.

We survey contracted rendering providers who have seen members during the survey period to:

- Assess their experience and level of satisfaction with NIA.
- Assess key aspects of the service they received from us while assisting our members.

**Provider/Facility Responsibility**

- Complete the survey within the time period indicated.
- Contact NIA with any comments, suggestions, or questions you may have.

**NIA's Responsibility**

- Monitor provider satisfaction with NIA and NIA's policies and procedures.
- Share aggregate results of our provider satisfaction surveys with our providers, customers, accreditation entities, and members.
- Use provider survey findings to identify opportunities for improvement and to develop and implement actions for improving our policies, procedures, and services.

# Rendering Provider Performance Monitoring

**Our Philosophy**

NIA has developed its rendering provider networks using strict selection standards on quality as evidenced in the Provider Assessment process. In order to ensure those quality standards are maintained after the initial contracting process has been completed, NIA has an established process for continuous monitoring of practice performance. In so doing, we are constantly working with our imaging facility providers to help members obtain appropriate, affordable diagnostic imaging services. This includes working closely with you to be sure we are incorporating your updated capabilities and quality results into our service database. This is all performed to accomplish our foundational goal of ensuring that consumers have access to high-quality diagnostic imaging resources.

**Our Policy**

Our process of evaluating quality performance by our contracted imaging facilities is multi-faceted and includes, but is not limited to, thorough credentialing, privileging, timely re-credentialing, and review of each provider's performance relative to the CMS Efficiency Measures. It is NIA's practice and policy to periodically share these findings as appropriate with our contracted imaging facilities and providers.

**Provider/Facility Responsibility**

- Ensure re-credentialing and other quality-related requests from NIA are responded to on a timely basis.
- Utilize performance information provided by NIA to assist you in making favorable modifications to your practice guidelines and patterns so as to fall within the preferred practice parameters.

**NIA's Responsibility**

- Monitor provider performance through the various methods in place.
- Utilize claims data to compare and evaluate, on an individual basis, each provider's practice patterns relative to CMS's established Efficiency Measures. NIA is iteratively implementing the eight CMS Efficiency Measures on a measure-by-measure basis. All CMS measures will be used in the evaluation process over time.
- Share results of NIA's CMS Efficiency Measures performance monitoring on an individual provider basis.
- Consult with NIA-contracted providers in identifying opportunities for improvement and to develop and implement action plans to effect those improvements.

# Fraud Waste and Abuse

**Our Philosophy**

NIA takes provider fraud, waste and abuse seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. NIA has made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law.

NIA promotes provider practices that are compliant with all federal and state laws on fraud, waste and abuse. Our expectation is that providers will submit accurate claims, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding which services to order for their patients.

**Our Policy**

NIA does not tolerate fraud, waste or abuse, either by providers or staff. Accordingly, we have instituted extensive fraud, waste and abuse programs to combat these problems. NIA's programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, waste and abuse in government programs and private insurance.

In order to monitor the services delivered to members, NIA maintains a comprehensive compliance program, including policies and procedures to address the prevention of fraud, waste and abuse. These policies can be viewed at the following link: https://www1.radmd.com/resources/policies-compliance.aspx after imaging facility login on NIA's website under My Practice/Resources/Fraud and Abuse Compliance Policies. Our policies in this area reflect that both NIA and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs (e.g., Medicare and Medicaid, federally funded contracts and private insurance. NIA complies with all applicable laws, including the Federal False Claims Act, state false claims laws applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded health care programs (e.g., Medicare Advantage, State Children's Health Insurance Program [SCHIP] and Medicaid) and other payers. Visit our website to review these policies.

**Provider/Facility Responsibility**

**Comply with All Laws and NIA Requirements**

Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse and do not violate any federal or state law relating to fraud, waste or abuse. Ensure that you provide services to members that are medically necessary and consistent with all applicable requirements, policies and procedures.

NIA expects all providers to:

- Comply with all federal and state laws regarding fraud, waste and abuse.

- Provide and bill only for medically necessary services that are delivered to members in accordance with NIA's policies and procedures and applicable regulations.
- Ensure that all claims submissions are accurate.
- Notify NIA immediately of any suspension, revocation, condition, limitation, qualification or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide health care services.

## Understand Fraud, Waste, Overpayment and Abuse

**Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other health care programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to federally and/or state-funded health care programs, and other payers.

**Overpayment** means any funds that a person receives or retains under Medicare, Medicaid, SCHIP, and other government funded health care programs to which the person, after applicable reconciliation, is not entitled under such health care program. It includes any amount that is not authorized to be paid by the health care program whether paid as a result of inaccurate or improper cost reporting, improper claiming practices, fraud, abuse, or mistake.

**Waste** means over-utilization of services or other practices that result in unnecessary costs.

Some examples of fraud, waste, overpayment and abuse include:

- Requesting authorizations or billing for services or procedures that have not been performed or have been performed by others.
- Submitting false or misleading information about services performed.
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement).
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment). Unpaid overpayments are also grounds for program exclusion.
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act.

- Routinely waiving patient deductibles or co-payments.
- Providing or ordering medically unnecessary services and tests based on financial gain.
- An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day (e.g., a provider requesting authorization separately for studies that are clinically required to be submitted as a combination request).
- Providing services in a method that conflict with regulatory requirements (e.g., unauthorized personnel providing clinical information to obtain authorizations).
- Treating all patients weekly regardless of medically necessity.
- Routinely maxing out of members' benefits or authorizations regardless of whether or not the services are medically necessary.
- Inserting a diagnosis code not obtained from a physician or other authorized individual.
- Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals).
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded health care programs.
- Lying about credentials, such as degree and licensure information. (e.g., provider misrepresentation of the physician when requesting authorization).

## Cooperate with NIA's Investigations

NIA's expectation is that you will fully cooperate and participate with its fraud, waste and abuse programs. This includes, but is not limited to, permitting NIA access to member treatment records and allowing NIA to conduct on-site audits or reviews. NIA also may interview members as part of an investigation, without provider interference.

## Report Suspected Fraud, Waste, Overpayment or Abuse

NIA expects providers and their staff and agents to report any suspected cases of fraud, waste or abuse. NIA will not retaliate against you if you inform us, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

Reports may be made to NIA via one of the following methods:

- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit E-mail: SIU@MagellanHealth.com
- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit E-mail: Compliance@MagellanHealth.com.

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

***Remember!***

NIA will not retaliate against you or any of its employees, agents and contractors for reporting suspected cases of fraud, waste, overpayments, or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits NIA from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. NIA also is prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.

**NIA's Responsibility**

NIA's responsibility is to implement and regularly conduct fraud, waste and abuse prevention activities that include:

- Extensively monitoring and auditing provider utilization and claims to detect fraud, waste and abuse.
- Actively investigating and pursuing fraud and abuse and other alleged illegal, unethical or unprofessional conduct.
- Reporting suspected fraud, waste and abuse and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations.
- Cooperating with law enforcement authorities in the prosecution of health care and insurance fraud cases.
- Verifying eligibility for members and providers.
- Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded health care programs.
- Training employees annually on NIA's Corporate Code of Conduct.
- Training employees and contracted providers on CMS Fraud Waste & Abuse.
- Making the NIA Provider Handbook available to network providers.

# Provider Exclusion from Federally or State-Funded Programs

**Our Philosophy**

NIA promotes provider compliance with all federal and state laws on provider exclusion and CMS preclusion requirements. The U.S. Department of Health and Human Services (HHS) through the Office of Inspector General (HHS-OIG) can exclude individuals and entities from participating in federally funded health care programs. The HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE) online. According to the HHS-OIG, "basis for exclusion includes convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans." "The effect of an OIG exclusion is that no Federal health care program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person. The exclusion and the payment prohibition continue to apply to an individual even if he or she changes from one health care profession to another while excluded. This payment prohibition applies to all methods of Federal health care program payment, whether from itemized claims, cost reports, fee schedules, capitated payments, a prospective payment system or other bundled payment, or other payment system and applies even if the payment is made to a State agency or a person that is not excluded. Excluded persons are prohibited from furnishing administrative and management services that are payable by the Federal health care programs. This prohibition applies even if the administrative and management services are not separately billable." Additional information is available by reviewing the *U.S. Health and Human Services Office of Inspector Special Advisory Bulletin: "Updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs - Issued May 8, 2013* (https://oig.hhs.gov/exclusions/files/sab-05092013.pdf).

In addition, the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database is used to identify individuals and entities excluded from receiving federal contracts, certain subcontracts and certain types of federal financial and non-financial assistance and benefits. The SAM Exclusion Database has replaced the Excluded Parties List System (EPLS), which is no longer in use.

States also can exclude individuals and entities from participating in state-funded contracts and programs.

CMS also prohibits a Medicare Advantage plan from paying, directly or indirectly, on any basis, for items or services furnished to a Medicare enrollee by any individual or entity that is included on the CMS Preclusion List. The Preclusion List is compiled by CMS and includes providers (individuals and entities) that fall within either of the following categories:

1. Are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or

2. Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

**Our Policy**

Consistent with federal and state requirements, any individual or entity excluded from participation in federally or state-funded contracts and programs cannot participate in any federally or state-funded health care program. NIA's policy is to ensure that excluded individuals/entities are not hired, employed or contracted by NIA to provide services for any of NIA's federally and state funded health care contracts including but not limited to contracts issued under Medicaid (Title XIX), Medicare (Title XVIII), or Social Services Block Grants (Title XX programs), or the State Children's Health Insurance Program (Title XXI). This policy is applicable to all NIA lines of business.

Consistent with CMS requirements, any individual or entity identified on the Preclusion List is not reimbursed, directly or indirectly, on any basis, for items or services furnished to a Medicare enrollee.

**Provider/Facility Responsibility**

Your responsibilities as required by the Centers for Medicare and Medicaid Services (CMS), further protects against payments for items and services furnished or ordered by excluded parties. If you participate in federally funded health care programs, you must take the following steps to determine whether your employees and contractors are excluded individuals or entities:

- Screen all employees, agents, and contractors to determine whether any of them have been excluded. Providers are required to comply with this obligation as a condition of enrollment as a Medicare or Medicaid provider.
- Search the HHS-OIG LEIE website at https://www.oig.hhs.gov/, the U.S. General Services Administration's (GSA) web-based System Award Management (SAM) Exclusion Database web site at , https://www.sam.gov/SAM/ and other applicable state exclusion/termination/suspension/sanction lists to capture sanctions, terminations, suspensions, exclusions and reinstatements that have occurred since the last search. You can search the website by individual or entity name.
- Immediately report to the respective state Medicaid Agency any exclusion information discovered.

In addition, to comply with NIA's fraud, waste and abuse programs, your responsibility is to:

- Check each month to ensure that you, your employees, agents, directors, subcontractors, officers, partners or persons with an ownership or control interest in you the provider/disclosing entity, or any individual/entity having a direct or indirect ownership or control interest in you the provider entity of **5** percent or greater are not terminated, debarred, suspended or otherwise excluded under the HHS-OIG LEIE at https://www.oig.hhs.gov/, the SAM Exclusion Database at https://www.sam.gov/SAM/ or any

applicable state exclusion/termination/suspension/sanctions List or barred from participating in any federal or state health care program.

- Immediately notify NIA in writing of the termination, debarment, suspension or exclusion of you, your employees, agents, subcontractors, directors, officers, partners or persons with an ownership or control interest in you the provider/disclosing entity, or any individual/entity having a direct or indirect ownership or control interest in you the provider entity of 5 percent or greater.
- Disclosure Requirements: Medicaid providers are required to disclose the following information regarding:
  (1) the identity of all *persons with an ownership or control interest* in the provider/disclosing entity; the identity of all *persons with an ownership or control interest,* in any subcontractor in which the disclosing entity/provider has a direct or indirect ownership interest of 5 percent or more*;* information about the type of relationships among the persons with ownership interest including information about the provider's agents and managing employees in compliance with 42 CFR 455.104.
  (2) certain business transactions between the provider and subcontractors/wholly owned suppliers in compliance with 42 CFR 455.105.
  (3) including you the provider, the identity of any person with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider or entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs in compliance with 42 CFR 455.106.

**NIA's Responsibility**

NIA's responsibility is to conduct fraud, waste and abuse prevention activities that include:

- Checking the SAM Exclusion Database, HHS-OIG LEIE, and applicable state exclusion lists during credentialing, prior to the employment of any prospective NIA employee and prior to contracting with any vendor, and monthly thereafter.
- Ensuring that excluded/terminated individuals/entities are not hired, employed or contracted by NIA to provide services for any of NIA's federally and state funded health care contracts including but not limited to contracts issued under Medicaid (Title XIX), Medicare (Title XVIII), or Social Services Block Grants (Title XX programs), or the State Children's Health Insurance Program (Title XXI).This policy is applicable to all NIA lines of business.
- Cooperate with law enforcement authorities in the prosecution of health care and insurance fraud cases, and report fraud-related data to federal and state agencies in compliance with applicable federal and state regulations and contractual obligations.

# Cultural Competency

| | |
|---|---|
| **Our Philosophy** | NIA is committed to a strong cultural competency program. NIA believes that all people entering the health care system must receive equitable and effective treatment in a manner that is respectful of individual consumer preferences, needs and values as well as sensitivity to residual stigma and discrimination. Aspects of this philosophy and approach are embedded throughout NIA policies. Compliance with these policies is contractually required for NIA providers. |
| **Our Policy** | To enable staff and network providers to deliver culturally competent care in an effective, understandable and respectful manner that is compatible with the members' cultural health beliefs, practices and preferred language. Services are designed to affirm and respect the worth of the individual and the individual's dignity. |
| **Provider/Facility Responsibility** | To ensure highest quality culturally competent service to members. |
| **NIA's Responsibility** | To emphasize and measure whether providers have a method to provide translation services, if needed, to the member. To ensure that providers and services are geographically, and culturally accessible to members.<br><br>Ensure that the updated version of the Cultural Competency Program Description is available on NIA's website, www.RadMD.com you can access it at the following link: https://www1.radmd.com/media/903262/culturalcompetency.pdf |

# Provider Reimbursement and Claims Filing Requirements

**Our Philosophy**

Depending upon the health plan customer, NIA may or may not process and/or pay claims to our providers. Regardless of the arrangement, NIA and its contracted payors are committed to reimbursing providers promptly and accurately in accordance with our contractual agreements. We strive to inform providers of claims processing requirements in order to avoid administrative denials that delay payment and require resubmission of claims.

**Our Policy**

NIA and its contracted payors reimburse imaging providers and facilities within prompt payment standards, according to member eligibility and benefit plans utilizing contracted rates and reimbursement schedules. NIA does not reward through financial incentives practitioners or other individuals for issuing denials. Our decisions are based only on appropriateness of care, service, and existence of coverage.

**Provider/Facility Responsibility**

- Complete all required fields on the HCFA-1500 (CMS 1500) or UB-04 (CMS 1450) form accurately.
- Collect applicable co-payments or co-insurance from members.
- Submit clean claims to be processed within the provision of covered services, unless state or federal laws or your provider contract indicate otherwise.
- Bill only for services rendered within the time span of the authorization.
- Contact NIA for direction if authorized services need to be used after the authorization has expired.
- Not bill the patient for any difference between your NIA contracted reimbursement rate and your standard rate. This practice is called balance billing and is not permitted by NIA.
- Comply with NIA's multiple procedure discount* policy. This NIA policy pertains only to imaging procedures for NIA contracted providers. Policies on multiple procedure discounts for non-NIA contracted providers may vary by NIA client.
    - NIA considers a single session to be one encounter where a member could receive one or more radiological studies. If more than one imaging service is provided to the member during one encounter, this constitutes a single session and the charge for the lower-priced procedure(s) will be reduced by 50 percent for the technical component and 5 percent for the professional component.
    - If a member has a separate encounter on the same day for a medically necessary reason and receives a second imaging service, these are considered multiple studies on the same day to be provided in separate sessions. The provider should use modifier -59 to indicate multiple sessions, and therefore the multiple procedure discount does not apply.

* Multiple procedure discounts will be applied to the technical and professional components of a global claim or services with the -TC modifier and –PC modifier.

### CPT Codes 76377 and 76376 (3D Imaging)

CPT codes 76377 or 76376 in conjunction with a CT or CTA primary code is not allowed for separate reimbursement. NIA's policy is that CPT codes 76376 and 76377 are considered all-inclusive with the primary procedure and, therefore, are not reimbursed separately.

**NIA's Responsibility**

- Process your claim promptly upon receipt and complete all transactions within regulatory and contractual standards.
- Inform you of any reasons for administrative action steps required to resolve the administrative denial.
- Comply with the terms of the agreement, including reimbursement for covered services rendered.
- Comply with applicable state and federal regulatory requirements regarding claims payment.
- Communicate changes to claims filing requirements and reimbursement rates in writing prior to the effective date.

# Medicare Beneficiaries

**Our Philosophy**

As a contracted supplier of healthcare management services to Medicare Advantage plans, NIA manages benefits for Medicare enrollees. As a Medicare Advantage plan contractor, NIA, along with our contracted provider network, is subject to the standards and procedures established by the Centers for Medicare & Medicaid Services (CMS).

**Our Policy**

Our Medicare network includes providers permitted by CMS to provide services to Medicare enrollees. We actively evaluate the cultural diversity of our networks to include providers who can meet the cultural needs of our members. In addition, our provider agreements are consistent with CMS requirements.

**Provider/Facility Responsibility**

NIA encourages all providers in our Medicare provider network to actively pursue information relevant to their roles in treating Medicare enrollees. CMS and Medicare information can be accessed directly at https://www.cms.gov.

As a provider in our Medicare network and to receive referrals of Medicare enrollees, you agree to:

- Be currently credentialed with NIA;
- Have an executed provider agreement with NIA that includes a Medicare addendum;
- Be free of any Medicare/Medicaid sanctions from the Office of the Inspector General (OIG);
- Have not opted out of Medicare;
- Have not been excluded or precluded from participation in Medicare;
- Accept referrals of Medicare enrollees for covered services within the scope of your practice;
- Deliver services in accordance with the terms of your provider agreement, the Medicare addendum, and the policies and procedures outlined in this handbook and applicable supplements;
- Comply with any CMS, NIA or Medicare Advantage health plan training requirements including, but not limited to, completion of Medicare Fraud, Waste and Abuse training (unless exempt based on enrollment in Original Medicare);
- Review and distribute to your employees any general compliance information communicated to you by NIA, including Magellan's Code of Conduct and/or compliance policies and procedures, to FDRs' (first tier, downstream and/or related entities) employees within 90 days of contract start date and annually thereafter;
- Inform NIA prior to engaging with an offshore subcontractor who will receive, process, transfer, handle, store, or access protected health information (PHI);
- Maintain records during the term of your agreement and for a period of 10 years following the termination of your agreement, or if records are subject to an audit, then maintain records for 10 years following the

termination of your agreement or the completion of any audit, whichever is later;

- Render all services in your office or facilities or in mutually agreeable locations;
- Deliver services in a culturally competent manner;
- Render services that are consistent with professionally recognized standards of healthcare;
- Protect the confidentiality of enrollees' information;
- Involve enrollees in treatment decisions;
- Be aware of and comply with laws applicable to individuals or entities receiving federal funds;
- Render services in a timely manner, consistent with NIA's access standards;
- For emergent cases (life-threatening or non-life-threatening), call Magellan upon stabilization of the enrollee. Preauthorization of emergency care is not required. An emergency is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, and is time-limited in intensity and duration;
- Render Urgently Needed Services (UNS) as needed. Preauthorization is not required. UNS are covered services provided when an enrollee is temporarily absent from a service area and when such services are medically necessary and immediately required:
  - As a result of an unforeseen illness, injury, or condition; and
  - When it is not reasonable, given the circumstances, to obtain services through Magellan.
- Be aware of, and document in the enrollee's record, whether an advance directive exists;
- Make sure services rendered are consistent with NIA's policies, quality improvement programs, applicable CMS local coverage determinations (LCDs) and national coverage determinations (NCDs), or other applicable clinical/care management guidelines and NIA's Care Guidelines.

*Note: For Medicare enrollees:*

- NIA follows CMS NCDs and LCDs where applicable. LCDs vary by state; NIA uses the LCD from the state where the service is provided.
- NCDs and LCDs supersede other state- and/or account-specific guidelines.
- The guideline applied in an organization determination decision for a Medicare enrollee will be specified in the authorization or denial letter.
- You may request a copy of the guideline by calling 1-800-327-0641;
- Participate in and cooperate with quality review and improvement activities related to services provided to enrollees;
- Adhere to Medicare appeals (reconsideration) procedures (including expedited appeals);
- Inform the enrollee or the enrollee's representatives of his/her right to appeal any treatment determination (even if the determination occurs "pre-service") before any service is delivered. You may be asked to provide information that is relevant to the reconsideration;

- Comply with CMS reporting requirements in a timely and accurate manner and certify to the truth and completeness of encounter data submitted to NIA;
- Maintain appropriate clinical records in accordance with Health and Human Services (HHS) and all other applicable federal, state, and local laws and regulations; and
  Adopt reasonable measures to prevent the unauthorized disclosure of Medicare records. Medical records must be maintained in a secure manner.

**NIA's Responsibility**

- Ensure compliance with the standards and procedures as outlined by the Centers for Medicare & Medicaid Services.

# Appendix A: Radiologist Quality Requirements

The NIA Participating Imaging Facility Agreement requires all facilities to confirm that all physicians servicing NIA members meet the NIA quality standards as outlined below.

Radiology practitioners not meeting these standards are not permitted to provide service to NIA members.

NIA reserves the right to audit and/or require documentation from contracted imaging facilities to verify compliance with these standards.

NIA's Radiology Quality Standards specify that all physicians must meet the following:

1. Hold a current license to practice medicine in the state in which they practice. The license must be unrestricted, unencumbered, and without other terms, conditions and/or limitations, including probationary status.
2. Have completed a radiology residency program accredited by the Accreditation Council for Graduate Medical Education for Radiology or the American Osteopathic Association or the Royal College of Physicians and Surgeons of Canada.
3. Hold current board certification from the American Board of Radiology (ABR) or American Osteopathic Board of Radiology (AOBR) certification.
4. Hold a current and unrestricted Federal Drug Enforcement Administration (DEA) registration, if required for scope of practice.
5. Hold a current and unrestricted state Controlled Dangerous Substances (CDS) registration (if required for scope of practice and applicable in state of practice).
6. Not be listed on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (OIG-LEIE), the U.S. General Services Administration's (GSA) web-based System Award Management (SAM) Exclusion Database, the CMS Preclusion List, and other applicable federal and state exclusion/termination/suspension/sanction lists, or have any applicable State Medicaid exclusions/sanctions.
7. Carry a minimum of professional liability insurance coverage of $1,000,000 per occurrence and $3,000,000 aggregate. Limits of professional liability insurance less than these amounts will be reviewed on a case by case basis by NIA.

The facility must verify credentials from primary sources at initial credentialing and recredentialing.

In addition, the facility will perform monthly ongoing monitoring of radiologists' credentials for sanctions or other adverse information. Ongoing monitoring includes, minimally:

- Licenses and any sanctions, disciplinary actions, conditions or limitations.
- Medicare/Medicaid sanctions or exclusions.
- Any criminal violations.
- Any subsequent malpractice actions where judgment, settlement is made on behalf of the radiologist.

# Appendix B: Payor Participation Schedule – Effective 2/1/2022

- Aetna (DE, NJ, NY, PA, WV)
- Ambetter:
    - Ambetter from Absolute Total Care
    - Ambetter from Arkansas Health &Wellness
    - Ambetter from Buckeye Community Health Plan
    - Ambetter from Coordinated Care
    - Ambetter from Home State Health Plan
    - Ambetter from Louisiana Healthcare Connections
    - Ambetter from Magnolia Health
    - Ambetter from Meridian (MI)
    - Ambetter from MHS
    - Ambetter from Nebraska Total Care
    - Ambetter from New Hampshire Healthy Families
    - Ambetter from Peach State Health Plan
    - Ambetter from Pennsylvania Health & Wellness
    - Ambetter from Silver Summit
    - Ambetter from Sunflower Health Plan
    - Ambetter from Sunshine Health
    - Ambetter from Superior
    - Ambetter from WellCare of Kentucky
    - Ambetter from WellCare of New Jersey
    - Ambetter from Western Sky Community Care
    - Ambetter of Illinois
    - Ambetter of North Carolina
    - Ambetter of Oklahoma
    - Ambetter of Tennessee
- AmeriHealth:
    - AmeriHealth Caritas Delaware
    - AmeriHealth Caritas District of Columbia
    - AmeriHealth Caritas Louisiana
    - AmeriHealth Caritas New Hampshire
    - AmeriHealth Caritas North Carolina
    - AmeriHealth Caritas Next of North Carolina
    - AmeriHealth Caritas Pennsylvania
    - AmeriHealth – Select Health of South Carolina
    - First Choice VIP Care
    - First Choice VIP Care Plus
- Arizona Complete Health
- Ascension Complete
- AvMed
- Blue Cross Blue Shield of Nebraska
- Blue Cross Blue Shield of South Carolina
- BlueCross BlueShield of Tennessee
- BlueChoice Health Plan
- Blue Shield of California
- Capital Blue Cross

- CareFirst CHPDC
- CareSource:
    - CareSource Advantage - Ohio
    - CareSource Georgia
    - CareSource Indiana
    - CareSource Ohio
    - CareSource Marketplace Georgia
    - CareSource Marketplace Indiana
    - CareSource Marketplace Kentucky
    - CareSource Marketplace Ohio
    - CareSource Marketplace West Virginia
    - CareSource PASSE AR
- Centene:
    - Absolute Total Care
    - Arkansas Total Care
    - Arkansas Health & Wellness
    - Buckeye Community Health Plan
    - California Health and Wellness
    - Carolina Complete Health
    - Care1st Health Plan Arizona
    - Coordinated Care
    - Home State Health Plan
    - Iowa Total Care
    - Louisiana Healthcare Connections
    - MeridianComplete Illinois
    - MeridianHealth Illinois
    - MeridianComplete Michigan
    - MeridianHealth Michigan
    - Magnolia Health Plan
    - Managed Health Services
    - Michigan Complete Health
    - Nebraska Total Care
    - New Hampshire Healthy Families
    - Peach State Health Plan
    - Pennsylvania Health & Wellness
    - SilverSummit Health Plan
    - Sunflower Health Plan
    - Sunshine Health/Staywell/Children's Medical Services
    - Superior Health Plan
    - Trillium Community Health Plan
    - Western Sky Community Care
    - YouthCare
- ConnectiCare
- Dean Health Plan/Previa 360
- Fidelis Care
- FloridaBlue
- Gateway Health – Now known as Highmark Wholecare

- Harvard Pilgrim Health Care
- Health Net of CA
- Health Net of OR
- Highmark Blue Cross BlueShield of Western New York
- Highmark Blue Shield of Northeastern New York
- HMSA (Hawai‘i Medical Service Association)
- Independent Health
- Keystone First
- Maryland Physicians Care
- MVP Health Care
- Presbyterian Health Plan
- QualChoice
- Tufts Health Plan
- Tufts Health Public Plans
- Virginia Premier Health Plan
- WellCare (AL, AR, AZ, CA, CT, FL, GA, IL, IN, KY, LA, MA, ME, MI, MO, MS, NC, NE, NH, NJ, NY, OH, OK, SC, RI, TN, TX, VT, WA)
- WellCare by AllWell (AR, AZ, FL, GA, IN, KS, LA, MO, MS, NM, NV, OH, OR, PA, SC, TX)
- WellFirst Health
- WPS Health Insurance

# Payor Participation Fee Schedule – Effective 1/1/2022

| Payor | State | Benefit Plan | Fee Schedules |
|---|---|---|---|
| Centene Sunshine State Health Plan | FL | Ambetter | Medicaid |
| Centene Sunshine State Health Plan | FL | Medicaid | Medicaid |
| Centene Sunshine State Health Plan | FL | WellCare by Allwell of FL | Medicaid |
| Centene PeachState | GA | Ambetter | Medicaid |
| Centene PeachState | GA | Medicaid | Medicaid |
| Centene PeachState | GA | WellCare by Allwell of GA | Medicare |
| Meridian Health Plan of Illinois, Inc. | IL | Ambetter | Medicaid |
| Centene Sunflower | KS | Medicaid | Medicaid |
| Centene Sunflower | KS | Well Care by Allwell of KS | Medicare |
| Centene Sunflower | KS | Ambetter | Medicaid |
| Centene HealthCare Connections | LA | Medicaid | Medicaid |
| Centene HealthCare Connections | LA | WellCare by Allwell of LA | Medicare |
| Centene Home State Health Plan | MO | Medicaid | Medicaid |
| Centene Home State Health Plan | MO | Ambetter | Medicaid |
| Centene Home State Health Plan | MO | WellCare by Allwell of MO | Medicare |
| Centene Healthy Families | NH | Medicaid | Medicaid |
| Centene Healthy Families | NH | Ambetter | Medicaid |
| Centene Western Sky | NM | Medicaid | Medicaid |
| Centene Western Sky | NM | Ambetter | Medicaid |
| Centene Western Sky | NM | WellCare by Allwell of NM | Medicare |
| Centene Silver Summit Health Plan | NV | Medicaid | Medicaid |
| Centene Silver Summit Health Plan | NV | Ambetter | Medicaid |
| Centene Silver Summit Health Plan | NV | WellCare by Allwell of NV | Medicaid |
| Centene Buckeye | OH | Ambetter | Medicaid |
| Centene Buckeye | OH | Medicaid | Medicaid |
| Centene Buckeye | OH | WellCare by Allwell of OH | Medicare |
| Centene Pennsylvania Health and Wellness | PA | WellCare by Allwell of PA | Medicare |

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|---|---|---|---|
| Centene Pennsylvania Health and Wellness | PA | Medicaid | Medicaid |
| Centene Pennsylvania Health and Wellness | PA | Ambetter | Medicaid |
| Centene Absolute Total Care | SC | Medicaid | Medicaid |
| Centene Absolute Total Care | SC | WellCare by Allwell of SC | Medicare |
| Centene Absolute Total Care | SC | Ambetter | Medicaid |
| Centene Ambetter of Tennessee | TN | Ambetter | Medicare |

# Appendix C: Frequently Asked Questions

In this section NIA provides answers to the most frequently asked questions from providers in the categories of credentialing, contracting and authorizations.

## Provider Assessment and Contracting

***What does an imaging provider or facility need to do to be considered an in-network provider with NIA?***

To be an in-network provider, the imaging provider or facility must be contracted and credentialed with NIA. Only when the provider assessment and contracting processes are completed is the facility considered an NIA in-network provider eligible to provide services to members.

***What are provider assessment, credentialing and privileging?***

In the provider assessment process, facilities must meet a set of credentialing criteria and/or privileging standards to be eligible to provide select services to our membership. Credentialing is the process we use to verify and periodically re-verify a provider and facility's credentials in accordance with our general credentialing criteria which can be found on www.RadMD.com. Privileging encompasses specific participation guidelines including facility accreditation, equipment capabilities, physician and technologist education, training and certification, and facility management components such as radiation safety guidelines. The process allows NIA to indicate down to the CPT code level the imaging procedures (both advanced and non-advanced imaging modalities) each location is qualified to perform.

***What does the credentialing and privileging process include?***

The credentialing process includes:

- **Administrative Verification** – We verify the provider or facility's licensure, accreditations, general and professional liability insurance coverages, malpractice history, and Medicaid/Medicare sanctions history. In addition, imaging equipment, physician and technician qualifications, and facility policies and procedures are evaluated to assign privileges for modality-specific procedures.
- **Committee Review** – If your facility's credentials satisfy NIA's standards, your facility's application and privileging results are evaluated by the Regional Network and Credentialing Committee (RNCC). This group is comprised of physicians, other clinicians and professional peers. The committee reviews applications subject to applicable state laws and our business needs. If your facility successfully completes the credentialing process and the programs and services are needed for members in your area, your facility will be accepted into the provider network pending execution of your facility's agreement.

***How long does the credentialing process take?***

Once all the required documents have been submitted, the credentialing process generally can be completed within 90 days

***How will our facility be notified if we are accepted into the NIA network?***

Upon acceptance into the NIA provider network, you will receive a welcome letter along with your fully executed Participating Imaging Facility Agreement.

***Will we be notified if our facility is not accepted into the NIA provider network?***
In the event that your facility is not accepted into the NIA provider network, you will be notified in writing.

***Once our facility completes the credentialing process, are the credentials good for the life of the contract?***
No. We re-review facility provider credentials and privileges every three years, or in compliance with regulatory and/or customer requirements, as a measure of our provider network quality. During this process, the facility's credentials are re-verified, privileges re-evaluated and the RNCC reviews your facility's credentials and privileges subject to applicable state laws and business needs. In addition, credentials and privileges are re-evaluated as needed when facilities report changes in accreditation, imaging equipment, staffing, or policies and procedures.

***What is the NIA Participating Imaging Facility Agreement?***
Your NIA Participating Imaging Facility Agreement is the contract between your facility and NIA to render diagnostic imaging services to members whose services are managed by NIA. The contract sets forth the terms and conditions of your facility's participation in the NIA network as well as the terms and conditions applicable to NIA.

## Authorizations

***Can a rendering provider obtain an authorization?***
NIA's policy indicates that ordering providers are responsible for obtaining authorization from NIA prior to referring members to rendering facilities; however, rendering providers may initiate authorization requests via www.RadMD.com, unless imaging study is urgent. If a study is urgent or emergent in nature, the rendering provider should contact NIA immediately with the appropriate clinical information for an expedited review. Access the Health Plan specific Quick Reference Guide for corresponding telephone numbers to call in the urgent request.

***How does the NIA participating Imaging Facility initiate a prior authorization for an imaging study?***
Requests for prior authorization must be submitted via the NIA web portal (www.RadMD.com) with the Imaging Facility's rendering provider access only.

***How does the NIA participating Imaging Facility verify whether an authorization was obtained for an imaging study?***
Providers can check the status of member authorizations quickly and easily by going to the website at www.RadMD.com. Upon logging in, access the My Exam Requests page. The facility may search based on the patient's ID number, patient name, or, if known, by the authorization number. Also, you may check the authorization status without having to login only if the tracking number is available.

***What does the NIA participating Imaging Facility do for an after-business hours or holiday pre-authorization need?***
If an emergency clinical situation exists outside of a hospital emergency room, please contact NIA directly with the appropriate clinical information for an expedited review. For non-emergency clinical situations, please utilize NIA website www.RadMD.com. RadMD is available 24/7, except when maintenance is performed.

***How is member eligibility obtained?***
Please call the phone number on the member's health benefit plan card.

***What does the NIA authorization number look like?***
The NIA authorization number consists of 8 or 9 alphanumeric characters (e.g., 1234X567).

***How can a provider know what codes will routinely be reimbursed?***
At the time NIA begins serving each health plan customer, we distribute to providers a Billable CPT-4 Codes Claim Resolution Matrix that will help providers know exactly what procedures NIA authorizes on behalf of the payor. These are also available online upon successful login.

***Are inpatient advanced imaging procedures included in this program?***
No. Inpatient imaging procedures are not included in this program.

***Which PET scans require prior authorization?***
Please refer to your health plan specific Billable CPT-4 Codes Claim Resolution Matrix for a list of procedures that require prior authorization.

***What happens if a patient is authorized for a CT of the abdomen, and the radiologist or rendering physician feels an additional study of the chest is needed?***
If the radiologist or rendering provider feels that, in addition to the study already authorized, an additional study is needed, please contact NIA immediately with the appropriate clinical information for an expedited review.

***What is the appeals process?***
Follow the instructions on your non-authorization letter or Explanation of Benefits (EOB)/ Explanation of Payment (EOP) notification.

# Appendix D: Contact Information By State

| State | Provider Relations Manager | Area Contract Manager |
|---|---|---|
| Alabama | *Anthony Salvati<br>Leta Genasci | Debbie Patterson |
| Alaska | Debbie Patterson | Debbie Patterson |
| Arizona | April Sabino | Debbie Patterson |
| Arkansas | Leta Genasci | Debbie Patterson |
| California | *April Sabino<br>Andrew Dietz | Debbie Patterson |
| Colorado | Gina Braswell | Wendy Hirn |
| Connecticut | *Charmaine Everett<br>April Sabino<br>Meghan Murphy | Wendy Hirn |
| Delaware | Charmaine Everett | Wendy Hirn |
| District of Columbia | Charmaine Everett | Wendy Hirn |
| Florida | *Andrew Dietz<br>Charmaine Everett<br>Leta Genasci | Debbie Patterson |
| Georgia | *Anthony Salvati<br>Meghan Murphy | Debbie Patterson |
| Hawaii | Laurie Kim | Debbie Patterson |
| Idaho | Andrew Dietz | Debbie Patterson |
| Illinois | Leta Genasci | Wendy Hirn |
| Indiana | *April Sabino<br>Meghan Murphy<br>Leta Genasci | Wendy Hirn |
| Iowa | Meghan Murphy | Wendy Hirn |
| Kansas | *Leta Genasci<br>Andrew Dietz | Debbie Patterson |
| Kentucky | *Meghan Murphy<br>Lori Fink | Wendy Hirn |
| Louisiana | Gina Braswell | Debbie Patterson |
| Maine | *April Sabino<br>Meghan Murphy | Wendy Hirn |
| Maryland | Charmaine Everett | Wendy Hirn |
| Massachusetts | *April Sabino<br>Charmaine Everett<br>Meghan Murphy | Wendy Hirn |
| Michigan | *Meghan Murphy<br>Leta Genasci | Wendy Hirn |
| Minnesota | Anthony Salvati | Wendy Hirn |
| Mississippi | Gina Braswell | Debbie Patterson |
| Missouri | *Anthony Salvati<br>Leta Genasci | Wendy Hirn |
| Montana | Anthony Salvati | Debbie Patterson |

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|---|---|---|
| Nebraska | Leta Genasci | Debbie Patterson |
| Nevada | April Sabino | Debbie Patterson |
| New Hampshire | *April Sabino<br>Lori Fink<br>Meghan Murphy | Wendy Hirn |
| New Jersey | Seth Cohen | Debbie Patterson |
| New Mexico | Gina Braswell | Debbie Patterson |
| New York | Charmaine Everett | Debbie Patterson |
| North Carolina | *Anthony Salvati<br>Lori Fink | Debbie Patterson |
| North Dakota | Anthony Salvati | Wendy Hirn |
| Ohio | *Meghan Murphy<br>Lori Fink | Wendy Hirn |
| Oklahoma | April Genasci | Debbie Patterson |
| Oregon | Debbie Patterson | Debbie Patterson |
| Pennsylvania | Lori Fink | Wendy Hirn |
| Rhode Island | *April Sabino<br>Meghan Murphy | Wendy Hirn |
| South Carolina | Anthony Salvati | Debbie Patterson |
| South Dakota | Anthony Salvati | Debbie Patterson |
| Tennessee | *Anthony Salvati<br>Leta Genasci | Debbie Patterson |
| Texas | Gina Braswell | Debbie Patterson |
| Utah | Andrew Dietz | Debbie Patterson |
| Vermont | Meghan Murphy | Wendy Hirn |
| Virginia | *Lori Fink<br>Charmaine Everett | Wendy Hirn |
| Washington | Debbie Patterson | Debbie Patterson |
| West Virginia | *Lori Fink<br>Meghan Murphy | Debbie Patterson |
| Wisconsin | *Gina Braswell<br>Leta Genasci | Wendy Hirn |
| Wyoming | Debbie Patterson | Debbie Patterson |

| **Provider Relations Managers** | | |
|---|---|---|
| **Name** | **Phone** | **Email** |
| Gina Braswell | 800-450-7281 X55726<br>952-225-5726 | braswellr@magellanhealth.com |
| Seth Cohen | 800-450-7281 X32418<br>410-953-2418 | cohens@magellanhealth.com |
| Andrew Dietz | 800-450-7281 X34636<br>407-967-4636 | dietza@magellanhealth.com |
| Charmaine Everett | 800-450-7281 X32615/<br>410-953-2615 | cseverett@magellanhealth.com |
| Lori Fink | 800-450-7281 X32621/<br>410-953-2621 | lafink@magellanhealth.com |
| Leta Genasci | 800-450-7281 X75518/<br>314-387-5518 | ljgenasci@magellanhealth.com |

| | | |
|---|---|---|
| Laurie Kim<br>Account Management/Provider Relations for Hawaii | 800-450-7281 X65704/<br>808-626-5704 | lekim@magellanhealth.com |
| Meghan Murphy | 800-450-7281 X31042<br>410-953-1042 | mamurphy@magellanhealth.com |
| April Sabino | 800-450-7281 X31078/<br>410-953-1078 | ajsabino@magellanhealth.com |
| Anthony Salvati | 800-450-7281 X75537/<br>314-387-5537 | alsalvati@magellanhealth.com |

| **Area Contract Managers** | | |
|---|---|---|
| **Name** | **Phone** | **Email** |
| Wendy Hirn | 800-450-7281 X59805/<br>224-935-9805 | wjhirn@magellanhealth.com |
| Debbie Patterson (Provider Relations coverage for Oregon and Washington) | 800-450-7281 x74799/<br>314-387-4799 | dlpatterson@magellanhealth.com |

*Please check payor specific provider education materials for designated Provider Relations Manager