National Imaging Associates, Inc. (NIA)
Frequently Asked Questions (FAQ's)
Ambetter from Superior HealthPlan
Prior Authorization Program
Physical Medicine Services

Question	Answer
General	
Why did Superior HealthPlan (Ambetter) implement a physical medicine utilization management program focusing on outpatient therapy services?	This physical medicine solution is designed to promote evidence based, high quality as well as cost-effective outpatient rehabilitative and habilitative physical (PT), occupational (OT), and speech (ST) therapy services for Ambetter members. This is accomplished through consistent application of best practice standards and evidence-based medical necessity guidelines.
Why did Ambetter select NIA?	NIA was selected to partner with Ambetter because of its clinically driven program designed to effectively manage quality and member safety, while ensuring appropriate utilization of resources for Ambetter members.
What services require prior authorization?	Prior authorization is required for all outpatient PT, OT, ST treatment services.
What types of providers are potentially impacted by this program?	Independent providers, hospital outpatient, and multispecialty groups rendering physical, occupational, and/or speech therapy need to ensure prior authorization has been obtained.
Does NIA require authorization for out of network therapy services for Ambetter?	No, NIA only manages authorization requests for therapy services that are performed by Ambetter contracted therapy providers. If you are not a contracted provider with Ambetter, please follow Ambetter's requirements for out of network requests.
Program Start	
What was the implementation date for this program?	Effective January 1, 2021, physical medicine services including PT, OT, and ST require prior authorization for all Ambetter members.
Is prior authorization required for the initial evaluation?	CPT codes for PT, OT, ST initial evaluations do not require an authorization for participating providers. However, all other billed CPT codes, even if performed on the same date as the initial evaluation date, require authorization prior to billing.

Is prior authorization necessary for outpatient therapy services if Ambetter is NOT the member's primary insurance?	Yes, authorization is required regardless if Ambetter is the primary or secondary insurer.
Which places of service are included in the program?	Therapy services must be rendered in the following locations: • Outpatient office • Outpatient hospital
Which places of service are excluded from the program?	Therapy services provided in the following are excluded from the program: • Hospital emergency departments • Inpatient hospital or observation status settings • Acute rehab hospitals • Skilled nursing facilities • Home health settings (requires prior authorization through Superior HealthPlan) The rendering provider should continue to follow Ambetter's policies and procedures for services performed in the above settings.
How are types of therapies defined?	**Rehabilitative Therapy** – Is a type of treatment or service that seeks to help a member 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 members develop skills or functions that they did not have and were incapable of developing on their own. This type of treatment tends to be common for pediatric members who have not developed certain skills at an age-appropriate level. **Neurological Rehabilitative Therapy** – Is a supervised program of formal training to restore function to members who have neurodegenerative diseases, spinal cord injuries, strokes, or traumatic brain injury. *Note: The simplest way to distinguish the difference between the two is habilitative is treatment for skills/functions that the member never had, while rehabilitative is treatment for skills/functions that the member had but lost.*

Prior Authorization Process	
How are prior authorization decisions made?	NIA makes medical necessity decisions based on the clinical information supplied by providers/facilities providing therapy services. Decisions are made as quickly as possible from submission of all requested clinical documentation. All decisions are rendered within state required timelines. Peer-to-peer telephone requests are available at any point during the prior authorization process. Clinical 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 therapy services?	The therapy services provider/facility is responsible for obtaining prior authorization for therapy services.
Do CPT codes used to evaluate a member require prior authorization?	Initial PT, OT, ST evaluation codes do not require authorization. It may be appropriate to render a service that does require authorization at the time of the evaluation. After the initial visit, providers have up to five business days to request approval for the first visit. If requests are received within this timeframe, NIA can backdate the start of the authorization to cover the evaluation date of service to include any other services rendered at that time.
Is prior authorization required for re-evaluations?	Re-evaluations require prior authorization for participating providers.
What do providers and office staff need to do to get therapy services authorized?	Providers are encouraged to utilize RadMD, (www.RadMD.com) to request prior authorization of therapy services. If providers are unable to use RadMD, they may call Ambetter Provider Services at 1-877-687-1196.
What kind of response time can providers expect for prior authorization of therapy 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, time for completion of these requests is within three calendar days.
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 therapy services to members if their name is not on the authorization?	Yes, the authorization is linked between the member's ID number and the facility's TIN. So long as the providers work under the same TIN and are of the same discipline, they can use the same authorization to treat the member.
If the servicing 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.
How do I obtain an authorization?	Authorizations may be obtained via RadMD (preferred method) or calling Ambetter Provider Services at 1-877-687-1196. The requestor will be asked to provide general provider and member information as well as some basic questions about the member's function and treatment plan. Based on the response to these questions, services may be approved immediately upon request. If we are not able to offer an immediate approval for services or the provider does not accept the authorization of services offered, additional clinical information may be required to complete the review. Clinical records may be uploaded through www.RadMD.com or faxed to 1-800-784-6864 using the **NIA specific fax coversheet** provided to you. If you need a copy of the fax coversheet, please contact your NIA Provider Relations Representative at 1-800-327-0641.
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: • Therapy providers may print the NIA specific fax coversheet from www.RadMD.com, request it during the initial phone call or by contacting NIA at 1-877-687-1196.

	• Use the 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. • NIA may fax this coversheet to the Therapy provider during authorization intake or at any time during the review process. • If you need a copy of the fax coversheet, please contact your NIA Provider Relations Representative at 1-800-327-0641. **Using an incorrect fax coversheet may delay a response to an authorization request.*

What information should you have available when obtaining an authorization?	▪ Name, address, and TIN of the facility.
	▪ Member name, ID number, and date of birth
	▪ Requesting/rendering provider type - PT, OT, ST
	▪ Date of initial evaluation
	▪ ICD-10 code(s)
	▪ Details justifying therapy
	  • Initial evaluation or re-evaluation findings
	  • Past medical history
	  • Member symptoms
	  • Prior treatment received for the same condition
	  • Functional outcome/standardized test scores
	  • Baseline functional status and impairments
	  • Objective tests and measures
	  • Plan of care/treatment plan
	  • Specific functional goals
	• Treatment interventions/modalities

If a provider has already obtained prior authorization and more visits are needed beyond what the initial authorization contained, does the provider have to obtain a new prior authorization?	Additional services on an existing authorization should NOT be submitted as a new request. If/when an authorization is nearly exhausted, additional visits may be requested as an addendum/addition to the initial authorization. To obtain additional services, clinical records will be required. Providers may upload these records through RadMD.

	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.
If a member is seen by one discipline for two or more sessions in one day, does it count as one visit or more?	Each date of service is calculated as a visit. Example: If a member is seen for group and individual physical therapy session on the same day, it will count as one visit towards the authorization.
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 when logged into 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 member 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 member is discharged from care.
If a member is being treated and the member now has a new diagnosis, will a separate authorization be required?	If a provider is in the middle of treatment and gets a new therapy prescription for a different body part, the treating provider will perform a new evaluation on that body part and develop goals for treatment. 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 visits and the appropriate ICD 10-code(s) to the existing authorization. If care is to discontinue on the previous area being treated and ongoing care will be solely focused on a new diagnosis, providers should submit a new request for the new diagnosis and include the discharge summary for the previous area. A new authorization will be processed, and the previous will be discontinued.
What is the most efficient way to submit prior authorization requests to avoid delays in member services?	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 Ambetter Provider Services at 1-877-687-1196.

	We will make every attempt to process authorization requests timely and efficiently upon receiving a request from a provider. 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. Providers may initiate a peer-to-peer by calling 1-877-687-1196. Requests initiated via fax require clinical validation and may take additional time to process. The fax number is 1-800-784-6864.
How are procedures that do not require prior authorization handled?	If no authorization is needed, claims will process through Ambetter. Providers are encouraged to submit claims electronically using Ambetter's Secure Provider Portal.
RECONSIDERATION AND APPEALS PROCESS	
Is the reconsideration process available once a denial is received?	The reconsideration process is not available once a denial determination has been made. NIA has a specialized clinical team focused on PT, OT, ST. Peer-to-peer discussions are offered for any request that does not meet medical necessity guidelines. The therapy provider may call 1-877-687-1196 to initiate the peer-to-peer process. These discussions provide an opportunity to discuss the case and collaborate on the appropriate services for the member based on the clinical information provided.
Whom should providers 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 Payment (EOP) notification.
RadMD Access	
What option should I select to receive access to initiate authorizations?	"**Physical Medicine Practitioner**" which will allow you access to initiate authorizations.
How do I apply for RadMD access to initiate authorization requests?	User would go to our website www.RADmd.com. • Click on "**New User**" • Choose "**Physical Medicine Practitioner**" from the drop-down box • Complete application with necessary information • Click "**Submit**" Once an application is submitted, the user will receive an email from our RadMD support team within a few hours after completing the application with an approved

	username and a temporary passcode. Please contact the RadMD support team at 1-800-327-0641 if you do not receive a response within 72 hours.
How can providers check the status of an authorization request?	Once logged into RadMD, 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?	Once logged into RadMD, providers can view clinical Information that has been received via upload or fax by selecting the member from 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?	Once logged into RadMD, providers can find links to case-specific communication to include requests for additional information and determination letters can be found via the "**View Request Status link**."
What does the authorization number look like?	The authorization number consists of at least 11 alpha-numeric characters (i.e., 12345ABC123). If the provider's authorization request is not approved at the time of initial contact, the ordering provider may instead receive a tracking number (i.e., 123456789). 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?	On the RadMD homepage, providers can utilize the "**Track an Authorization**" feature, which allows 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.
How can I receive notifications electronically instead of paper?	Communication, including final determination, will be paperless/electronic. Correspondence for each case is sent to the email of the person submitting the initial authorization request. Users will be sent an email when determinations are made. Note: • No PHI will be contained in the email. • The email will contain a link that requires the user to log into RadMD to view PHI. When initiating a request, providers who prefer paper communication can choose the option to continue receiving communications via fax.
Whom can I contact if we need RadMD support?	For assistance or technical support, please contact RadMDSupport@Evolent.com or call 1-800-327-0641.

	RadMD is available 24/7, except when maintenance is performed once every other week after business hours.
Contact Information	
Whom can a provider contact at NIA for more information?	If you have a question or need more information about this program, you may contact the NIA Provider Service Line at 1-800-327-0641. You may also contact your dedicated NIA Provider Relations Manager: Gina Braswell Senior Clinical Provider Relations Manager 1-800-450-7281 Ext. 55726 OR 1-952-225-5726 gbraswell@Evolent.com
Whom can a provider contact at Ambetter if they have questions or concerns?	Contact Ambetter Provider Services at 1-877-687-1196.