National Imaging Associates, Inc. (NIA)
Frequently Asked Questions (FAQs)
Sunflower Health Plan
Prior Authorization Program
Physical Medicine Services

Question	Answer
General	
When did the Physical Medicine Services program transition to a Prior Authorization program for Sunflower Health Plan?	Effective June 1, 2020, physical medicine services (physical therapy, occupational therapy, and speech therapy) are no longer managed through a post-service review process for Sunflower Health Plan. Sunflower Health Plan remains committed to ensuring that physical medicine services provided to our members are consistent with nationally recognized clinical guidelines. The utilization management of these services is managed by NIA through a prior authorization program.
What services require prior authorization?	Prior authorization is required for all treatment rendered by a Physical Therapist, Occupational Therapist, or Speech Therapist for a Sunflower Health Plan Member.
Is prior authorization required for the initial evaluation?	The CPT codes for PT, OT and ST initial evaluations do not require an authorization. However, all other billed CPT codes even if performed on the same date as the initial evaluation date will require authorization prior to billing. After the initial visit, providers have 1 business day to request approval for the first visit. If requests are received timely, NIA is able to backdate the start of the authorization to cover the evaluation date of service to include any other services rendered at that time.
Which Sunflower Health Plan members are covered under this relationship and what networks are used?	NIA manages Physical Medicine Services for all Sunflower Health Plan members who will be utilizing Physical Medicine services (Physical Therapy, Occupational Therapy, and Speech Therapy). NIA manages physical medicine services through Sunflower Health Plans network of providers that perform physical medicine services.
Is prior authorization necessary for Physical	No. This program applies to members who have Medicaid through Sunflower Health Plan as their primary insurance.

Medicine Services if Sunflower Health Plan is NOT the member's primary insurance?	
What services are included in this Physical Medicine Program?	All outpatient Physical Therapy, Occupational Therapy and Speech Therapy services are included in this program in the following setting locations: • Outpatient Office • Outpatient Hospital
Which services are excluded from the Physical Medicine Program?	Therapy provided in Hospital ER, Inpatient and Observation status, Acute Rehab Hospital Inpatient, Home Health and Inpatient and Outpatient Skilled Nursing Facility settings are excluded from this program. The treating provider should continue to follow Sunflower Health Plan's policies and procedures for services performed in the above settings.
Why did Sunflower Health Plan implement a physical medicine utilization management program?	This physical medicine solution is designed to promote evidence based and cost effective Physical Therapy, Occupational Therapy, and Speech Therapy services for Sunflower Health Plan members.
Why focus on Physical Therapy, Occupational Therapy, and Speech Therapy services?	A consistent approach to applying evidence-based guidelines is necessary so Sunflower Health Plan members can receive high quality and cost effective physical medicine services.
How are types of Therapies defined?	Rehabilitative Therapy – Is a type of treatment or service that seeks to help a patient regain a skill or function that was lost as a result of being sick, hurt or disabled. Habilitative Therapy – Is a type of treatment or service that seeks to help patients develop skills or functions that they didn't have and were incapable of developing on their own. This type of treatment tends to be common for pediatric patients who haven't developed certain skills at an age-appropriate level. The simplest way to distinguish the difference between the two is Habilitative is treatment for skills/functions that the patient never had, while Rehabilitative is treatment for skills/functions that the patient had but lost. Neurological Rehabilitative Therapy – Is a supervised program of formal training to restore function to patients

	who have neurodegenerative diseases, spinal cord injuries, strokes, or traumatic brain injury.
What types of providers will potentially be impacted by this physical medicine program?	Any independent providers, hospital outpatient, and multispecialty groups rendering Physical Therapy, Occupational Therapy, and/or Speech Therapy services will need to ensure prior authorization has been granted.
Prior Authorization Process	
How are prior authorization decisions be made?	NIA makes medical necessity decisions based on the clinical information supplied by practitioners/facilities providing physical medicine services. Decisions are made as quickly as possible from submission of all requested clinical documentation (one business day for urgent requests). All decisions are, at minimum, rendered within State required timelines. Peer-to-peer telephone requests are available at any point during the prior authorization process. NIA's clinical review team consists of licensed and practicing Physical Therapists, Occupational Therapists, Speech Therapists and board-certified physicians. Clinical determinations are rendered only by clinical peer reviewers with appropriate clinical experience and similar specialty expertise as the requesting provider. Clinical peer reviewers will be available for peer-to-peer requests as necessary consultation as needed. The Sunflower Health Plan appeals process is available if a provider disagrees with a prior authorization determination.
Who is responsible for obtaining prior authorization of the procedure?	Responsibility for obtaining prior authorization is the responsibility of the physical medicine practitioner/facility rendering and billing the identified services. A physician order may be required for a member to engage with the physical medicine practitioner, but the provider rendering the service is ultimately responsible for obtaining the authorization based on the plan of care they establish. Approval and denial letters are sent to the member, and physical medicine practitioner. Sunflower Health Plan contracts generally do not allow balance billing of members. Please make every effort to

	ensure that prior authorization has been obtained prior to rendering a physical medicine service.
Will CPT codes used to evaluate a member require prior authorization?	Initial PT, OT and ST evaluation codes do not require authorization. It may also be appropriate to render a service that does require authorization at the time of the evaluation. After the initial visit, providers will have up 1 business day to request approval for the first visit. If requests are received timely, NIA is able to backdate the start of the authorization to cover the evaluation date of service to include any other services rendered at that time.
What do providers and office staff need to do to get a physical medicine service authorized?	Providers contact NIA using the RadMD website, www.RadMD.com or calling 1-877-644-4623 to obtain authorization for physical medicine services. Call center hours are 7 a.m. to 7 p.m. (CST) Monday through Friday. RadMD is available 24 hours each day, 7 days a week.
What kind of response time can providers expect for prior authorization of physical medicine requests?	NIA leverages a clinical algorithm to assist in making real time decisions at the time of the request based on the requestors' answers to a few simple clinically based questions. If we cannot offer immediate approval, generally the turnaround time for completion of these requests is within 2 to 3 business days upon receipt of sufficient clinical information. There are times when cases may take up to the maximum timeframe if additional information is needed, but that is not the norm.
If the referring provider fails to obtain prior authorization for the procedure, will the member be held responsible?	This prior authorization program will not result in any additional financial responsibility for the member, assuming use of a participating provider, regardless of whether the provider obtains prior authorization for the procedure or not. The participating provider may be unable to obtain reimbursement if prior authorization is not obtained, and member responsibility will continue to be determined by plan benefits, not prior authorization. If a procedure is not prior authorized in accordance with the program and rendered: • In an outpatient setting at/by a Sunflower Health Plan participating provider, benefits will be denied, and the member will not be responsible for payment.

How do I obtain an authorization?	Authorizations may be obtained by the physical medicine practitioner via the online portal, www.RadMD.com or via phone at 1-877-644-4623. The requestor will be asked to provide general provider and patient information as well as some basic questions about the member's function and treatment plan. Based on the response to these questions, a set of services may be offered real-time. If we are not able to offer a real-time approval for services or the provider does not agree to accept the authorization, additional clinical information may be required to complete the review. Clinical records may be uploaded via RadMD or faxed to 1-800-784-6864 using the coversheet provided.
What information should you have available when obtaining an authorization?	• Diagnosis(es) being treated (ICD10 Code) • Requesting/Rendering Provider Type – PT, OT, ST • Date of the initial evaluation at their facility • Type of Therapy: Habilitative, Rehabilitative, Neuro Rehabilitative • Surgery date and procedure performed (if applicable) • Date the symptoms started • Planned interventions (by billable grouping category) and frequency and duration for ongoing treatment. • How many body parts are being treated, and is it right or left? • The result of the Functional Outcome Tool used for the body part evaluated. The algorithm is looking for the percentage the patient is functioning with their current condition. Example: If a test rated them as having a 40% disability, then they are 60% functional. • Summary of functional deficits being addressed in therapy.
How do I confirm physical medicine benefits for a member?	Member benefits, benefit limitations and number of visits remaining for the year should be confirmed through Sunflower Health Plan's Customer Service. Member benefits are calculated by visits per year. Each date of service is calculated as a visit.
If a provider has already obtained prior authorization and more visits are needed beyond what the initial auth contained, does the	Additional services on an existing authorization should NOT be submitted as a new request. If/when an authorization is nearly exhausted, additional visits may be requested as an addendum/addition to the initial authorization. To initiate a request for additional care, providers can use the fax cover sheet from the initial

provider have to obtain a new prior authorization?	authorization to submit updated clinical records or may load these records to the existing authorization in RadMD. To obtain additional services, clinical records will be required. Providers may upload these records through RadMD or fax them to NIA at 1-800-784-6864 using the coversheet provided at the time of the initial authorization. Additional fax coversheets may also be printed from RadMD or requested via phone at 1-877-644-4623. If the member needs to be seen for a new condition, or there has been a lapse in care (more than 30 days) and care is to be resumed for a condition for which there is an expired authorization, providers should submit a new initial request through RadMD or via telephone at 1-877-644-4623.
What if I just need more time to use the services previously authorized?	A one-time 30-day date extension on the validity period of an authorization is permitted and can be requested via phone at 1-877-644-4623 or by submitting an electronic request through RadMD or fax to 1-800-784-6864 using the coversheet provided. Date extensions are subject to any benefit limits that may restrict the length of time for a given condition/episode of care. Extensions beyond the initial 30-day request or outside of any benefit constraints may require clinical records to be submitted.
If a patient is discharged from care and receives a new prescription or the validity period ends on the existing authorization, what process should be followed?	A new authorization will be required after the one-time 30-day extension or if a patient is discharged from care.
If a patient is being treated and the patient now has a new diagnosis, will a separate 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 ended.
Could the program potentially delay services and inconvenience the member?	A prior authorization request can easily be initiated via RadMD or telephone at 1-877-644-4623 within a few minutes. In cases where additional clinical information is needed, a peer to peer consultation with the provider may be necessary and can be initiated by calling 1-877-644-4623. Responses to NIA requests for additional clinical information or peer to peer are needed to ensure a timely review and determination. Requests initiated via fax require clinical validation and may take additional time to process. The fax number is 1-800-784-6864.
What happens in the case of an emergency?	The NIA website, www.RadMD.com cannot be used for medically urgent or expedited prior authorization requests during business hours. Those requests must be processed by calling the NIA call center at 1-877-644-4623.
How are procedures that do not require prior authorization handled?	If no authorization is needed, the claims will process according to Sunflower Health Plan's claim processing guidelines.
Peer to Peer Reviews/Appeals and Re-Review Process	
What is a Peer to Peer Review and when can a provider initiate a Peer to Peer review with NIA?	Peer to Peer discussions provide an opportunity to discuss the case with NIA Physician Reviewers and to collaborate on the appropriate services for the patient based on the clinical information provided. The Peer-to-peer process can be initiated once the case has been submitted for review or after the initial denial; however, a case cannot be overturned based on this discussion. A provider must submit something in writing to overturn the denial. The phone number to initiate a peer-to-peer is 1-877-644-4623.
If a provider disagrees with a physical medicine determination made by NIA, is there a re-review process or an option to appeal the determination?	In the event of any sort of adverse determination the provider can request a re-review by sending in new information that was not previously reviewed. Re-reviews on determinations may be made within 3 business days. If the denial is upheld after the re-review and the provider still disagrees with the decision, NIA will instruct the provider to start the formal appeal using the original denial letter. Peer-to-peer consultations can be conducted anytime during normal business hours, or as required by Federal or State regulations.

RadMD Access	
What option should I select to receive access to initiate authorizations?	"Physical Medicine Practitioner" which will allow you access to initiate authorizations.
How do I apply for RadMD access to initiate authorization requests?	User would go to our website, www.RadMD.com. • Click on NEW USER. • Choose "Physical Medicine Practitioner" from the drop-down box • Complete application with necessary information. • Click on Submit Once an application is submitted, the user will receive an email from our RadMD support team within 72 hours after completing the application with their approved username and a temporary passcode. Please contact the RadMD Support Team at 1-877-80-RadMD (1-877-807-2363) if you do not receive a response with 72 hours. Your RadMD login information should not be shared.
What is rendering provider access?	Rendering provider access allows users the ability to view all approved authorizations for their office or facility. If an office is interested in signing up for rendering access, you will need to designate an administrator. • User would go to our website, www.RadMD.com • Select "Facility/Office where procedures are performed" • Complete application • Click on Submit Examples of a rendering facility that only need to view approved authorizations: • Hospital facility • Billing department • Offsite location • Another user in location who is not interested in initiating authorizations Once an application is submitted, the user will receive an email from our RadMD support team within 72 hours after completing the application with their approved username and a temporary passcode. Please contact the RadMD Support Team at 1-877-80-RadMD (1-877-807-2363) if you do not receive a response with 72 hours. Your RadMD login information should not be shared.

Who can I contact if we need RadMD support?	For assistance or technical support, please contact RadMDSupport@Evolent.com or call 1-877-80-RadMD (1-877-807-2363). RadMD is available 24/7, except when maintenance is performed once every other week after business hours.
Paperless Notification	
How can I receive notifications electronically instead of paper?	NIA has paperless notifications. Please follow this process if you are interested in receiving paperless notifications: 1. During each RadMD-initiated request, the user will be given the option to receive an electronic notification instead of via mail. a. Once selected, electronic notification will be used for all notifications for that authorization only. b. Each time a request is entered on RadMD, the user must choose electronic or mail notification. 2. If the user opts to receive electronic notification, an email will be sent when a determination is made. a. No PHI will be contained in the email. b. The email will contain a link that requires the user to log into RadMD to view PHI. 3. A note is entered into the request to reflect email notification was given and to whom the email note was addressed.
Contact Information	
Who can a provider contact at NIA for more information?	If you have a question or need more information about this physical medicine prior authorization program, you may contact the NIA Provider Service Line at: 1-800-327-0641. You may also contact your dedicated NIA Provider Relations Manager: Andrew Dietz 1-800-450-7281, ext. 34636 adietz@Evolent.com