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

Question	Answer
General	
When does the Physical Medicine services program require a Prior Authorization for Ambetter from Buckeye Health Plan?	Effective January 1, 2021, Physical Medicine services (Physical, Occupational, and Speech Therapy) will require Prior Authorization for all services provided to all Ambetter from Buckeye Health Plan members.
What services now require prior authorization?	Prior authorization will be required for all treatment rendered by a Physical, Occupational, or Speech Therapist for an Ambetter from Buckeye Health Plan member.
Will NIA require authorizations for out of network physical medicine services for Ambetter from Buckeye Health Plan?	No, NIA will only be managing the authorization requests for physical medicine services that are performed by Ambetter from Buckeye Health Plan contracted physical medicine providers. If you are not a contracted provider with Ambetter from Buckeye Health Plan, please follow the Ambetter from Buckeye Health Plan requirements for out of network requests.
Will a prior authorization be required for the inital evaluation?	The CPT codes for Physical, Occupational and Speech Therapy 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, will require authorization prior to billing.
Which Ambetter from Buckeye Health Plan members will be covered under this relationship and what networks will be used?	• NIA will manage Physical Medicine services for all Ambetter from Buckeye Health Plan who will be receiving these services • NIA manages Physical Medicine services through Ambetter from Buckeye Health Plan's network of providers that perform physical medicine services.

Is prior authorization necessary for Physical Medicine Services if Ambetter from Buckeye Health Plan is NOT the member's primary insurance?	No. This program applies to members through Ambetter from Buckeye Health Plan as their primary insurance.
What services are included in this Physical Medicine Program?	All outpatient Physical, Occupational, and Speech Therapy services are included in this program in the following setting locations: • Outpatient Office • Outpatient Hospital • Home Health
Which services are excluded from the Physical Medicine Program?	Therapy provided in Hospital ER, Inpatient and Observation status, Acute Rehab Hospital Inpatient, Inpatient and Outpatient Skilled Nursing Facility settings are excluded from this program. The rendering provider should continue to follow Ambetter from Buckeye Health Plan's policies and procedures for services performed in the above settings.
Why is Ambetter from Buckeye Health Plan implementing a Physical Medicine utilization management program?	This physical medicine solution is designed to promote evidence based and cost-effective Physical, Occupational, and Speech Therapy services for Ambetter from Buckeye Health Plan members.
Why focus on Physical, Occupational, and Speech Therapy services?	A consistent approach to applying evidence-based guidelines is necessary so Ambetter from Buckeye 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 obtained. This program is effective for all services rendered on or after Date for all Ambetter from Buckeye Health Plan membership.
Prior Authorization Process	
How will prior authorization decisions be made?	NIA will make medical necessity decisions based on the clinical information supplied by practitioners/facilities providing physical medicine services. Decisions are made as quickly as possible from submission of all requested clinical documentation (1 business day not to exceed 72 hours for urgent requests). 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 the Physical Medicine services?	The physical medicine practitioner/facility is responsible for obtaining prior authorization for Physical Medicine services. A physician order may be required for a member to engage with the physical medicine practitioner, but the provider rendering the service is ultimately responsible for obtaining the authorization based on the plan of care they establish. Determination letters are sent to the member, and physical medicine practitioner. Ambetter from Buckeye 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 Physical, Occupational and Speech Therapy 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 will have up to 5 business days for outpatient setting 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 will providers and office staff need to do to get a Physical Medicine service authorized?	Providers are encouraged to utilize RadMD, (www.RadMD.com) to request prior authorization of Physical Medicine services. If a provider is unable to use RadMD, they may call 1-877-687-1189. RadMD and the Call Center will be available beginning December 14, 2020 for prior authorization for dates of service January 1, 2021 and beyond. Any services rendered on and after January 1, 2021 will require authorization. Prior authorization is required for members that are currently receiving care which will continue on or after January 1, 2021. Authorizations obtained prior to the start of the program will reflect an effective date of January 1, 2021 and beyond.
What kind of response time can providers expect for prior authorization of Physical Medicine requests?	NIA does leverage a clinical algorithm to assist in making real time decisions at the time of the request based on the requestors' answers to clinically based questions. If we cannot offer immediate approval, generally the turnaround time for completion of these requests is within 2 to 3 business days upon receipt of sufficient clinical information. There are times when cases may take longer if additional information is needed.
Who is the "Ordering/ Treating Provider" and "Facility/Clinic?"	The ordering/treating provider is the therapist who is treating the member and is performing the initial therapy evaluation. The facility/clinic should be the primary location where the member is receiving care. You will be required to list both the treating provider and the rendering facility when entering the prior authorization request in RadMD. If you are not utilizing RadMD,

	please have the information available at the time you are initiating your request through the Call Center.
Can multiple providers render physical medicine services to members if their name is not on the authorization?	Yes, the authorization is linked between the members ID number and the facility's TIN. So long as the providers work under the same TIN and are of the same 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. If a procedure is not prior authorized in accordance with the program and rendered at/by an Ambetter from Buckeye 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 RadMD (preferred method) or via phone at 1-877-687-1189. 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 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 via www.RadMD.com or faxed to 1-800-784-6864 using the coversheet provided.
How do I send clinical information to NIA if it is required?	The most efficient way to send required clinical information is to upload your documents to RadMD (preferred method). The upload feature allows clinical information to be uploaded directly after completing an authorization request. Utilizing the upload feature expedites your request since it is automatically attached and forwarded to our clinicians for review. If uploading is not an option for your practice, you may fax utilizing the NIA specific fax coversheet. To ensure prompt receipt of your information:

	• Use the NIA fax coversheet as the first page of your clinical fax submission. *Please do not use your own fax coversheet, since it will not contain the case specific information needed to process the case • Make sure the tracking number on the fax coversheet matches the tracking number for your request • Send each case separate with its own fax coversheet • Physical Medicine Practitioners may print the fax coversheet from www.RadMD.com or contact NIA at 1-888-642-7649 to request a fax coversheet online or during the initial phone call • NIA may fax this coversheet to the Physical Medicine Practitioner during authorization intake or at any time during the review process. *Using an incorrect fax coversheet may delay a response to an authorization request.
What information should you have available when obtaining an authorization?	• Member name / DOB • Member ID • Diagnosis(es) being treated (ICD10 Code) • Requesting/Rendering Provider Type – PT, OT, 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/standardized outcome measure used for the body part evaluated. The algorithm is looking for the percentage the patient is functioning with their current condition. Example: If a test rated them as having a 40% disability, then they are 60% functional • Summary of functional deficits being addressed in therapy.

If a patient 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 patient is seen for group and individual physical therapy session on the same day, it will count as one visit towards the authorization.
If a provider has already obtained prior authorization and more visits are needed beyond what the initial auth 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.
What if I just need more time to use the services previously authorized?	A 30-day date extension on the validity period of an authorization is permitted and can be requested by utilizing the “Request Validity Date Extension” option on RadMD. Date extensions are subject to any benefit limits that may restrict the length of time for a given condition/episode of care.
If a patient is discharged from care and receives a new prescription or the validity period ends on the existing authorization, what process should be followed?	A new authorization will be required after the authorization expires or if a patient is discharged from care.
If a patient is being treated and the patient 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.
Could the program potentially delay services and inconvenience the member?	We will make every attempt to process authorization requests timely and efficiently upon receiving a request from a provider. We recommend utilizing www.RadMD.com as the preferred method for submitting prior-authorization requests. If your request cannot be initiated through our portal, you may initiate a request by calling: 1-877-687-1189. In cases that cannot be immediately approved and where additional clinical information is needed, a peer-to-peer consultation with the provider may be necessary and can be initiated by calling 1-888-642-7649. Requests initiated via fax require clinical validation and may take additional time to process. The fax number is 1-800-784-6864.
What happens in the case of an emergency?	The NIA Website www.RadMD.com cannot be used for medically urgent or expedited prior authorization requests during business hours. Those requests must be processed by calling the NIA call center at 1-877-687-1189.
How are procedures that do not require prior authorization handled?	If no authorization is needed, the claims will process according to Ambetter from Buckeye Health Plan's claim processing guidelines.
RECONSIDERATION AND APPEALS PROCESS	
Is the reconsideration process available for the physical medicine program once a denial is received?	Once a denial determination has been made, if the office has new or additional information to provide, a re-review/reconsideration can be initiated by uploading via RadMD or faxing (using the case specific fax cover sheet) additional clinical information to support the request. A reconsideration must be initiated within 5 business days from the date of denial and prior to submitting a formal appeal. NIA has a specialized clinical team focused on physical medicine services. Peer-to-peer discussions are offered for any request that does not meet medical necessity guidelines. The physical medicine provider may call 1-888-642-7649 to initiate the peer to peer process. These discussions provide an opportunity to discuss the case and collaborate on the appropriate services for the patient based on the clinical information provided.

Who should a provider contact if they want to appeal a prior authorization decision?	Providers are asked to please follow the appeal instructions given on their non-authorization letter or Explanation of Benefits (EOB) notification.
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 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?	Providers can check on the status of an authorization by using the "View Request Status" link on RadMD's main menu.
How can I confirm what clinical information has been uploaded or faxed to NIA?	Clinical Information that has been received via upload or fax can be viewed by selecting the member on the View Request Status link from the main menu. On the bottom of the "Request Verification Detail" page, select the appropriate link for the upload or fax.
Where can providers find their case-specific communication from NIA?	Links to case-specific communication to include requests for additional information and determination letters can be found via the View Request Status link.
What will the authorization number look like?	The authorization number consists of at least 11 alpha-numeric characters (i.e., 12345ABC123). In some cases, the ordering provider may instead receive a tracking number (i.e., 123456789) if the provider's authorization request is not approved at the time of initial contact. Providers will be able to use either number to track the status of their request online or through an Interactive Voice Response (IVR) telephone system.
If I did not submit the initial authorization request, how can I view	The "Track an Authorization" feature will allow users who did not submit the original request to view the status of an authorization, as well as upload clinical

the status of a case or upload clinical documentation?	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.
Paperless Notification: How can I receive notifications electronically instead of paper?	NIA defaults communications including final authorization determinations to paperless/electronic. Correspondence for each case are sent to the email of the person submitting the initial authorization request. Users will be sent an email when determinations are made. • 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. Providers who prefer paper communication will be given the option to opt out and receive communications via fax.
Who can I contact if we need RadMD support?	For assistance or technical support, please contact RadMDSupport@MagellanHealth.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	
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: Meghan Murphy 1-800-450-7281, ext. 31042 mamurphy@magellanhealth.com
Who can a provider contact at Ambetter from Buckeye Health Plan if they have questions or concerns?	Contact Ambetter from Buckeye Health Plan provider services at 1.877.687.1189. Providers may access the Ambetter from Buckeye Health Plan portal: https://ambetter.buckeyehealthplan.com