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

Question	Answer
General	
Why is Superior implementing 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 Superior Medicaid (STAR, STAR+PLUS*) and CHIP members*. This is accomplished through consistent application of best practice standards and evidence-based medical necessity guidelines. ** For Medicaid STAR+PLUS members, this expansion is only applicable to non- STAR+PLUS HCBS Waiver members.* *Please note: Prior authorization is not required for member receiving Early Childhood Intervention (ECI) services.*
Why did Superior select NIA?	NIA was selected to partner with Superior because of its clinically driven program designed to effectively manage quality and member safety, while ensuring appropriate utilization of resources for Superior members.
What services now require prior authorization?	Prior authorization will be required for all PT, OT, ST treatment services rendered by an in-network licensed physical, occupational or speech therapist.
What types of providers will potentially be impacted by this new program?	Any independent providers, outpatient, nursing facilities, home health and multispecialty groups rendering physical, occupational, and/or speech therapy treatment will need to ensure prior authorization has been obtained. Providers who are not a licensed therapist, (physicians, podiatrist, chiropractors, etc.) must submit prior authorization requests to Superior.
Is prior authorization required for out of network providers?	Yes, a prior authorization request must be submitted to Superior.

Program Start	
What is the implementation date for this new program?	Any therapy treatment scheduled to occur on or after December 1, 2021, will require prior authorization through NIA. Beginning November 29, 2021, RadMD and the NIA Call Center will be available to request authorization for services on or after December 1, 2021.
Will a prior authorization be required for the initial evaluation?	The 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, will require authorization prior to billing.
Is prior authorization necessary for outpatient therapy services if Superior is NOT the member's primary insurance?	Yes, authorization is required regardless if Superior 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 facilities • Home health • Skilled nursing facilities
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 The rendering provider should continue to follow Superior'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 due to 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 will prior authorization decisions be made?	NIA will make 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. Prior authorization requests are reviewed by licensed clinicians with similar clinical expertise.
Who is responsible for obtaining prior authorization of therapy services?	The therapy services provider/facility is responsible for obtaining prior authorization for therapy services.
Will CPT codes used to evaluate a member require prior authorization?	Initial PT, OT, and ST evaluation CPT codes do not require authorization. All other billed codes, even if performed on the same date as the initial evaluation, will require authorization prior to billing. After the initial visit, providers will have up to three business days to request approval for the first visit. If requests are received within this timeframe, NIA can backdate the authorization to include other services rendered on the same day as the evaluation.
Will a prior authorization be required for re-evaluations?	No.
What will providers and office staff need to do to get therapy services authorized?	Providers are encouraged to utilize www.RadMD.com to request prior authorization of therapy services. If providers are unable to use the website, they may call 1-800-642-7554. Beginning November 29, 2021, RadMD and the NIA Call Center will be available to request authorization for services on or after December 1, 2021. Any services

	rendered on and after December 1, 2021, will require authorization. Authorizations obtained prior to the start of the program will reflect an effective date of December 1, 2021, and beyond.
What is the response time providers can expect from NIA for determination of prior authorization requests?	A determination will be made within 3 business days.
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 by the therapist by utilizing RadMD (preferred method) or calling 1-800-642-7554. The requestor will be asked to provide general provider and member information as well as the number of visits and start/end dates of care. Clinical documentation will also 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 NIA at 1-800-642-7554.
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 1-800-642-7554. • 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 NIA at 1-800-642-7554. **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 ▪ Requested start and end dates of service ▪ Requested number of visits ▪ ICD-10 code(s) ▪ Attestation of physician order ▪ 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	Additional services on an existing authorization should NOT be submitted as a new request. If/when an authorization is nearly exhausted, additional visits may

visits are needed beyond what the initial authorization contained, does the provider have to obtain a new prior authorization?	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.
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.
What happens if a member has a new injury that requires a change to the plan of care?	A new authorization is not needed. A subsequent request to the existing authorization can be initiated on RadMD. You will be required to upload additional documentation to support the requested change in the plan of care.
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 1-800-642-7554. We will make every attempt to process authorization requests timely and efficiently upon receiving a request from a provider. In cases where additional clinical information is needed, a therapist-to-therapist consultation with NIA may be necessary. 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, the claims will process through Superior. Providers are encouraged to submit claims electronically using Superior's Secure Provider Portal.
APPEALS PROCESS	
Whom should providers contact if they want to appeal a prior authorization decision?	For prior authorization medical necessity appeals, please follow the instructions on your denial letter.
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 will the authorization number look like?	The authorization number consists of at least 11 alpha-numeric characters (i.e., 12345ABC123). Before a determination is made, 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?	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@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	
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 1-800-642-7554. You may also contact your dedicated NIA Provider Relations Manager: Gina Braswell, OTR/L Senior Clinical Provider Relations Manager 1-800-450-7281 Ext. 55726 OR 1-952-225-5726 braswellr@magellanhealth.com
Whom can a provider contact at Superior if they have questions or concerns?	Contact Superior Provider Services at 1-877-391-5921.