National Imaging Associates, Inc.
Imaging Provider Handbook

Table of Contents

Welcome to the NIA Provider Handbook!

This provider handbook is your reference guide for navigating radiology benefits management with National Imaging Associates (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; in addition to details about our credentialing, privileging and contracting policies; information about the NIA prior authorization process; a summary of our quality improvement program; and information about the NIA claims payment process.

The appendices in this handbook contain more extensive information, including our:

- Provider Assessment criteria,
- Tips on submitting electronic claims,
- Payor participation schedule, and
- Answers to frequently asked questions.

> Access Provider Self-service at:
>
> www.RadMD.com

This handbook also provides information about the provider self-service features available to you on our Web site. Please be aware that by accessing the online provider services located at www.RadMD.com, you can accomplish virtually all the business tasks you'll need to complete with NIA—in one convenient online location. So please sign in and get started.

We hope you find this a helpful tool in working with NIA to provide quality care to members. We welcome your feedback on how we can make our handbook even better and more helpful to you. Comments can be e-mailed to EditorNIA@MagellanHealth.com.

About NIA

National Imaging Associates, Inc. is a subsidiary of Magellan Health Services — the country's leading diversified specialty health care management organization. NIA is one of the largest and fastest growing radiology benefits management companies in the United States, managing diagnostic imaging services for millions of members nationwide. NIA's product line currently includes its core business, management of advanced radiology services, and several other radiologically focused programs including but not limited to: CardiacConnections®, Obstetrical Ultrasound (OB US) and OncologyConnections.

In all of these programs, NIA is dedicated to improving the quality of patient care through clinically appropriate and cost-effective use of diagnostic imaging. We achieve improved patient care in a physician-supportive, patient-centric manner that also enhances the financial performance of our customer organizations.

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 "providers," "imaging providers" or "imaging facilities") to deliver optimal health outcomes to members. NIA shares the following objectives with our network providers:

- Delivering the right exam at the right time for members—in part to avoid non-contributory exams that may delay diagnoses.

- 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 radiology 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 also support you by emphasizing prompt claims payment—offering advanced and easily accessible systems for the submission, adjudication and payment of provider claims (according to the client-specific claims submission arrangements). And again, we make available a host of provider services on our Web site to help you obtain the information and assistance you need. All of 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 or BLS certified physician supervision on-site during contrast enhanced procedures and physician on-site during normal business hours, and facility management components such as radiation safety guidelines (i.e., 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.

What You Need to Do

The **credentialing process** requires that you:
- Complete the online NIA Provider Assessment application on RadMD.com and submit all required documents, including documentation of current accreditation, licensure and/or certification, and insurance. **Incomplete applications will not be processed.**
- 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 or otherwise excluded under the HHS/OIG List of Excluded Individuals ("LEIE List"); the General Service Administration's Excluded Parties List System ("EPLS"); or any applicable State exclusion list where services are rendered or delivered.
- Hold current applicable licensure for radiology equipment and materials.

- Have 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 Imaging Facility Agreement.
- Cooperate with additional NIA credentialing verification activities for radiologists, as requested.
- Conduct primary source verification (PSV) of the credentials of other medical and clinical staff members, as required.
- Meet certain modality-specific quality criteria, such as the presence of an ACLS-certified or BLS-certified physician on site during contrast-enhanced procedures, equipment guidelines, etc.
- 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.
- Provide current credentialing guidelines on RadMD.com.

The **privileging process** requires that you:

- Complete NIA's online Provider Assessment application on RadMD.com. The online tool has intuitive user interface capability and is very easy to use.

Based on the information the provider submits, NIA is able to identify provider capabilities and indicate down to the CPT code level the imaging procedures (both advanced and non-advanced imaging modalities) that each location is approved to perform.

What NIA Will Do

NIA will:
- Provide you with notification on how to access the NIA Provider Assessment Application for the provider assessment (credentialing and privileging) process.
- Direct you to www.RadMD.com to complete the Provider Assessment application. Complete the provider assessment process within industry guidelines, or state- or customer-established timeframes, whichever is shorter.
- Complete your provider assessment application process with final review by the NIA Credentialing Committee.
- Notify you in writing upon the completion and outcome of the provider assessment or privileging process.

- Provide current privileging guidelines on RadMD.com.

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.

What You Need to Do

Your responsibility is to:
- 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 control.
- Successfully complete the provider assessment 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.

What NIA Will Do

NIA's responsibility to you is to:
- Provide an NIA 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 completed, signed and returned the agreement to NIA.
- Provide the fully executed agreement, signed by both parties, for your records.
- Comply with the terms of the agreement, including reimbursement for covered services rendered.
- Operate a Facility Selection Support (FSS) program. This program is designed to assist ordering providers and members to identify the most conveniently located participating providers. NIA also offers a Consumer Portal to provide consumers with access to cost, quality and convenience information related to 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 media to communicate with our providers about policies, procedures, and expectations, including but not limited to the RadMD.com Web site, 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 and verifies all changes with the provider.

What You Need to Do Your responsibility is to:
- 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 Web site to obtain updated information about your exam request authorizations and claims, 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 your service or program information, including but not limited to changes in facility ownership (including a change in Taxpayer Identification Number, and/or NPI), name, address, or telephone number, as well as the ability to accept referrals, including any program closure. Submit changes to your Area Contract Manager, or you may mail or fax written changes to:

      NIA – Radiology Network Services
      MO61
      14100 Magellan Plaza
      Maryland Heights, MO 63043
      Fax number: 314-292-1151

What NIA Will Do

NIA's responsibility to you is to:

- Provide an NIA Area Contract Manager and Provider Relations Manager. Each provider is assigned an Area Contract Manager as a single point of contact for credentialing, contracting and communicating changes made to your program. 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 with claims payment questions through national and local customer service lines during business hours.
- Offer assistance regarding provider assessment and contracting and program/practice changes through our national toll-free Radiology Network Services line at 1-800-327-0641.
- Communicate information about policies, procedures and expectations in a timely manner.
- Update provider records accurately and in a timely manner, verifying changes with the provider.

Appeals and Complaints

We are committed to maintaining strong, mutually beneficial 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 can address them in a timely manner. The following are the appropriate contacts for appeals and complaints:

- Network Participation[1] - Contracting: NIA maintains a network that is of an appropriate size to meet the needs of covered members in a given 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 Area Contract Manager or the Radiology Network Services line at 1-800-327-0641.
- Network Participation[2] - Provider Assessment: NIA follows provider assessment criteria to assess providers' suitability for network participation. On occasion providers have credentials that may not meet the letter of the criteria but meet the intent. To appeal NIA's provider assessment decision, please send your appeal to:

---

[1] NIA operates within statutes for each state and Commonwealth including "any willing provider" laws.
[2] NIA operates within statutes for each state and Commonwealth including "any willing provider" laws.

NIA – Radiology Network Services
MO61
14100 Magellan Plaza
Maryland Heights, MO 63043
Fax number: 314-292-1151

Upon initial denial, providers have a set time 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 provision, 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.

NIA does not permit a rendering provider to contractually accept delegation of responsibility for the complete authorization submission from the referring provider. NIA also does not permit rendering providers to present themselves as referring providers in order to obtain complete authorizations. These practices could violate federal or state laws or terms and conditions of a provider contract or benefit plan. Therefore, NIA investigates all situations where this type of activity is suspected or reported.

In the event of an urgent test, a rendering provider may initiate the authorization, but NIA will contact the ordering physician to authenticate the referral and obtain the necessary clinical information.

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 procedural categories require prior authorization; specific modalities requiring prior authorization will vary by customer and are summarized in supplemental provider communications. *A separate authorization number is required for each procedure ordered.*

- CT/CTA/CCTA Scan
- MRI/MRA
- PET Scan
- Diagnostic Nuclear Medicine
- Nuclear Cardiology/MPI
- Echocardiography
- Stress Echo
- Radiation Oncology
- Obstetrical Ultrasound

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

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.

What You Need to Do

As a provider of diagnostic imaging services that require 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.
- If a patient calls to schedule an appointment for a procedure that requires authorization, but does not have the authorization number, direct him or her back to the ordering physician.

To further comply with this policy, your responsibility is to:
- Contact NIA to obtain timely prior authorization or check on the status of existing authorization for the ordered diagnostic imaging services.
- 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.

What NIA Will Do

NIA's responsibility to you is to do the following in a prompt manner:
- 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.

What You Need to Do   To comply with this policy, your responsibility is to:

- 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.

What NIA Will Do   NIA's responsibility to you is to:

- 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.

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.

What You Need to Do

To comply with this policy, your responsibility is to:
- Review non-authorization letter or Explanation of Benefit (EOB)/Explanation of Payment (EOP) notification for:
  - The specific reason(s) for the adverse determination;
  - Appeal rights, including your right to dispute a determination on your own behalf;
  - Appeal procedures and submission timeframe; and
  - Any specific documents required for submission in order to complete a review of your appeal.
- Follow the process described in the non-authorization letter or EOB/EOP determination notice to submit an appeal.
- Submit all the appeal information in a timely manner.

What NIA Will Do

NIA's responsibility to you is to:
- Inform you in writing, in a clear and understandable manner, the specific reasons for the adverse determination.
- Inform you of options available to you after an unfavorable benefit determination, from a pre-certification review or claim.
- Identify the appeal rights afforded to the member.
- Thoroughly review all information submitted for an appeal.
- Respond to appeal requests in a timely manner.

Patient Access

The imaging facility shall provide covered services within the timeframes provided in NIA Policies and Procedures. The imaging facility should also refer to NIA client-specific performance guidelines in their corresponding NIA Provider Agreement Exhibits.

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 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 share these rights and responsibilities with members at the time of their first appointment with you.

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.

What You Need to Do

To comply with this policy, your responsibility is to:

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

What NIA Will Do

NIA's responsibility is to:

- Distribute the NIA Member Rights and Responsibilities 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. Such 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, including assessment of providers not accredited within one year of their inclusion in the imaging provider network.

* Acceptable recognized accreditation for providers includes: accreditation for MRI and CT by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (ICAMRL, ICACTL); accreditation for PET by the ACR or ICANL; 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. Non-accredited providers may have certain site visit requirements satisfied when CMS or state licensure agency on-site visits are equivalent to NIA standards.

What You Need to Do   To comply with this policy, your responsibility is to:

- 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.

What NIA Will Do   NIA's responsibility to you is to:

- 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.

Member Satisfaction

Our Philosophy

Member satisfaction is one of our core performance measures. Obtaining member input is an essential component of our quality program.

Our Policy

Annually, we may (where delegated) survey a representative sample of members who have received imaging services to:
- Assess their experience and satisfaction with NIA; and
- Assess key aspects of the care and/or services received from network imaging providers.

What You Need to Do

To comply with this policy, your responsibility is to:
- Provide safe, high-quality care and service to members you treat;
- Be responsive to members' concerns and questions; and
- Encourage members to provide feedback on the care and services received.

What NIA Will Do

NIA's responsibility is to:
- Inform you of aggregate survey findings and respond to any questions you may have regarding the surveys; and
- Use member survey findings to identify opportunities for improvement and to develop and implement actions for improving our policies, procedures, and services.

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 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; and
- Assess satisfaction with our utilization management decisions and support services.

We survey contracted rendering providers who have seen members during the survey period to:
- Determine their level of satisfaction with NIA; and
- Assess key aspects of the service they received from us while assisting our members.

What You Need to Do

To comply with this policy, your responsibility is to:
- Complete the survey within the time period indicated; and
- Contact NIA with any comments, suggestions, or questions you may have.

What NIA Will Do

NIA's responsibility is to:
- 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; and
- 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.
What You Need to Do	To comply with this policy, your responsibilities are to: • 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.
What NIA Will Do	NIA's responsibility is to: • Monitor provider performance through the various methods in place. • Utilize NIA's 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 and Abuse Program Compliance Program

Our Philosophy

NIA is subject to both federal and state laws designed to prevent fraud and abuse in government programs (such as Medicare and Medicaid) and private insurance. In addition to preventing fraud and abuse, these laws are designed to ensure that health care providers exercise their best independent judgment when deciding which services to order for their patients, and also prevent situations that could lead the provider to providing goods or services that are not medically necessary.

In order to monitor the services delivered to our 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 after imaging facility login on NIA's Web site at www.RadMD.com under My Practice/Resources/Fraud and Abuse Compliance Policies.

Our Policy

NIA, in conjunction with appropriate government agencies, actively pursues all suspected fraud and abuse. As part of NIA's corporate compliance program for the prevention of fraud and abuse, NIA complies with the Deficit Reduction Act (DRA) of 2005 and all state and federal billing requirements for government-sponsored programs (e.g., Medicare and Medicaid), and other payers, including the Federal False Claims Act, State False Claims laws and Whistleblower Protection laws. These can be viewed at the NIA Web site location shown above.

NIA checks the Health and Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals/Entities (OIG's LEIE), Cumulative Sanction Report and General Services Administration's List of Parties Excluded (EPLS) from federal procurement and non-procurement programs, and applicable state exclusion lists, for names of excluded employees, contractors, providers, and vendors barred from participation in Medicare, Medicaid, other federal health care programs, federal contracts, and state health care programs. Excluded individuals or entities are not hired, employed, or contracted by NIA to provide service for any of NIA's product offerings. This policy is applicable to all NIA lines of business.

What You Need to Do

To comply with this policy, your responsibility is to:
- Bill only for medically necessary services delivered to members, in accordance with NIA's policies and procedures.
- Comply with the Federal False Claims Act and any applicable State False Claims Laws, including administrative remedies for false claims and statements, applicable state laws that provide civil or criminal penalties for making false claims and statements, the "whistleblower"

protections afforded under such laws, and the role of such laws in preventing and detecting fraud, waste and abuse in government sponsored health care programs. It is important to check the state laws link on NIA's Web site periodically, as the laws are subject to change.

- Routinely check to ensure that you, your employees and subcontractors are not debarred, suspended, or otherwise excluded under the Department of Health & Human Services Office of Inspector General List of Excluded Individuals/Entities ("OIG-LEIE") at http://exclusions.oig.hhs.gov/; the General Service Administration's (GSA) Excluded Parties List System ("EPLS") at http://www.epls.gov/ or any applicable state exclusion list where the services are rendered or delivered.

- Routinely check to ensure that you, your directors, officers, partners or owners with a five percent (5%) or more controlling interest are not debarred, suspended or otherwise excluded under the OIG-LEIE at http://exclusions.oig.hhs.gov/; the General Service Administration's Excluded Parties List System ("EPLS") at http://www.epls.gov/ or any applicable state exclusion list where the services are rendered or delivered.

- Immediately notify NIA in writing of the debarment, suspension, or exclusion of yourself, your employees, subcontractors, directors, officers, partners or owners with a five percent (5%) or more controlling interest.

- Notify NIA immediately of any Health and Human Services (HHS) Office of Inspector General (OIG) action or proposed action to exclude you, your employees, directors, officers, partners or owners with a five percent (5%) or more controlling interest.

- Comply with NIA's policy not to accept delegation of responsibility by any ordering/referring provider for submitting the request for authorizations or to represent yourself as a referring provider in order to obtain a complete authorization.

What NIA Will Do

NIA's responsibility is to conduct fraud and abuse prevention activities that include:
- Review of alleged illegal, unethical or unprofessional conduct;
- Eligibility verification for members and providers;
- Internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid;
- Monitoring of service utilization to detect fraud or abuse;
- Post-payment utilization review to detect fraud and abuse;
- Internal monitoring and auditing;
- Annual NIA employee training on NIA's Corporate Compliance Handbook;

- Making the NIA Imaging Provider Handbook available to network providers;
- Ensuring that NIA does not hire, employ, or contract with individuals and entities that are listed on the OIG's LEIE, EPLS, and applicable state exclusions lists, prior to contracting and monthly thereafter; NIA checks the OIG's LEIE list at http://exclusions.oig.hhs.gov/, the GSA EPLS list at http://www.epls.gov/ , and applicable state exclusion lists; and
- Provider audits and investigations.

Claims Filing Requirements

Our Philosophy

Depending upon the health plan customer, NIA may or may not process and/or pay claims to our providers. Where we are fully delegated for claims payment, NIA is committed to reimbursing our 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 reimburses imaging providers and facilities within prompt payment standards, according to member eligibility and benefit plans utilizing contracted rates and reimbursement schedules.

What You Need to Do

To comply with this policy, your responsibility is to:
- Complete all required fields on the CMS-1500 or UB-04 form accurately.
- Collect applicable co-payments or co-insurance from members.
- Submit a clean claim to be reimbursed for the remainder of your contracted reimbursement amount. See the Claims Tips in Appendix B.
- Submit claims for services delivered in conjunction with the terms of your agreement with NIA.
- Use only standard code sets as established by the Centers for Medicare and Medicaid Services (CMS) or the state of your licensure for the specific claim form (UB-04 or CMS-1500) you are using. (You can find additional information under the subsequent *Billing Codes and HIPAA Compliance* section.)
- Submit claims within 60 days of the provision of covered services.
- 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.
- o 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.

* The multiple procedure discount does not apply to imaging services billed with the -26 modifier, which denotes the professional component. The multiple procedure discount will be applied to the technical component of a global claim or services with the -TC 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.

What NIA Will Do

NIA's responsibility to you is to:
- Process your claim promptly upon receipt, and complete all transactions within regulatory and contractual standards.
- Inform you of any reasons for administrative denials and action steps required to resolve the administrative denial.
- Include all applicable reimbursement schedules as exhibits to your contract.
- 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.

Electronic Claims Submission

Our Philosophy

Depending upon the health plan customer, NIA may or may not be delegated to process and/or pay claims to our providers. Where we are fully delegated for claims payment, NIA offers a variety of methods through which providers can submit claims electronically to support our providers' submission preferences. This enhances our ability to pay providers in a timely and accurate manner.

Our Policy

NIA is committed to meeting the Centers for Medicare and Medicaid Services (CMS) and HIPAA (Health Insurance Portability and Accountability Act) compliance standards. NIA offers a claim submission tool for professional claims and a direct-submit option for providers able to transmit data in a HIPAA-compliant 837 format. Both of these options are available on NIA's Web site and are offered at no cost to our providers. In addition, we have several contracted clearinghouses through which both facility-based claims and professional claims can be submitted.

What You Need to Do

To comply with this policy, your responsibility is to:

- Evaluate the Claims Courier application on NIA's Web site (accessible under My Claims/Submit a Claim Online). This tool has functionality that allows providers to submit claims typically completed on a CMS-1500. The application allows providers to efficiently submit a new claim, view the status of a claim, and use previously submitted claims to create a new claim.
- If you are able to transmit data in a HIPAA-compliant 837 format, submit claims directly to NIA through a direct-submit upload process. Information about this process is available via www.RadMD.com. If you have any questions or need assistance, feel free to contact us at EDISUPPORT@ MagellanHealth.com or our EDI Hotline at 314-387-5890 or toll-free at 800-450-7281, extension 75890.
- Consider using the services of one of our contracted clearinghouses (listed in Appendix B) if you submit a high volume of claims, or for claims typically submitted on a UB-04.

What NIA Will Do

NIA's responsibility to you is to:

- Ensure that we maintain easily accessible, provider-friendly systems for online claim submission through NIA.
- Continue to maintain Web-based claims applications and relationships with clearinghouses to assure flexibility in the claims submission process.
- Provide Electronic Funds Transfer (EFT) and Electronic Remittance

Advice (835) for electronic claims.

Billing Codes and HIPAA Compliance

Our Philosophy We offer support to our providers by providing recommended HIPAA-compliant billing codes. Using these codes for electronic transactions benefits NIA and our providers, resulting in prompt and accurate claims payment.

Our Policy NIA requires the use of standard code-sets approved by the Centers for Medicare and Medicaid Services (CMS) for HIPAA compliance where they apply to our business requirements. Standard code sets include ICD-9-CM diagnosis codes for billing, CPT® and HCPCS procedural codes with modifiers, revenue, type of bill, discharge status codes, type of service and place of service codes. These code sets are required for electronic claims.

What You Need to Do To comply with this policy, your responsibility is to:
- Use the current version of ICD-9-CM codes on claim submissions.
- Use current CPT® and HCPCS codes to bill for imaging services on a CMS- 1500.
- Obtain your National Provider Identifier (NPI) number for use in submitting HIPAA-standard electronic transactions to NIA.
- Review the Claims Filing Requirements section in this handbook for additional claims submission information.
- Order ICD-9-CM manuals from the American Medical Association (AMA) by calling 1-800-621-8335 or from Channel Publishing at 1-800-248-2882. A CD-ROM of the complete listing can be ordered from the United States Government Printing Office at: U.S. Government Printing Office, P.O. Box 979050, St. Louis, MO 63197-9000, or by calling the Ordering Office at 1-866-512-1800.
- Obtain CPT® codes that are copyrighted by and can be obtained through the American Medical Association.
- Obtain HCPCS codes from the Centers for Medicare & Medicaid Services (CMS) at www.cms.hhs.gov.
- Note: All code sets are reviewed and subject to modification annually, so it is important to have the most current version of these codes for billing purposes.

What NIA Will Do NIA's responsibility to you is to:
- Inform you of how to find the current HIPAA-compliant code sets through CMS and the AMA.
- Request from CMS, and/or the code-set owners, assignment of appropriate coding for standard services, when gaps are identified.

- Share your NPI number with various health care partners in order to facilitate compliance with the HIPAA transaction requirements.

Appendix A
Claims Tips
(This section applies to those NIA clients who delegate claims processing and payment to NIA)

Claims Tips
-- DO --

✓ **Do Give Complete Information on the Member and Policy Holder**

Please provide complete information for items such as the name, birth date, sex, and relationship for both the member and the policyholder. Verify that this information matches the patient's insurance card. Watch out for name variations and changes. Errors and omissions of these items can cause an unnecessary delay in processing the claim.

✓ **Do Give Complete Information on You, the Provider**

Please provide complete information regarding the provider, including the names of both the treating provider and the billing entity. The Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) number for the billing entity must be provided for the claim to be processed correctly. The billing or remittance address must be accurate for the check and/or Explanation of Benefits to be sent to the correct party. Medicare encounter reporting standards require us to collect and report the NPI number of the rendering provider. The degree level of the provider of service is needed to determine reimbursement amounts.

✓ **Do Include Any Other Carrier's Payment Information**

If another health plan is the primary insurer and benefits have been provided or denied, include primary insurer's payment information in compliance with Coordination of Benefits rules.

✓ **Do Include the Complete Procedural Code(s)**

If the patient has more than one procedure, please be sure to report all procedures on the claim. Appropriate modifiers should be used to indicate appropriate bundling and unbundling of billed services. The procedure must match your authorization and the HCPCS codes for facilities or CPT codes for professional services.

✓ **Do Obtain Authorization for Services**

Most benefit plans and procedures require authorization prior to rendering services. Please verify with the member's benefit plan if you are not sure if authorization is required.

✓ **Do Show Your Entire Charge**

Always show your full charge on the claim. The amount that is reimbursed is based on the lesser of billed charges or the applicable reimbursement schedule.

✔ **Do Submit Your Claims Electronically and Within Timely Filing Guidelines**

Submit your claims in HIPAA-compliant ASC X12 837 format within 60 days of the Covered Service directly to NIA or through an NIA-preferred clearinghouse. Your NPI number is required on all electronic claim submissions.

✔ **Do Monitor Your EDI Transaction Reports**

Monitor your EDI transaction reports on a regular and timely basis and correct rejected claims.

Claims Tips
-- DON'T--

✓ **Don't Use Invalid Procedure or Diagnosis Codes**

Only use current code sets (CPT, HCPCS, and ICD-9) and select the codes that most accurately describe the service provided. Codes other than CPT are generally not accepted in most NIA claims processing systems. The claim may not be altered by the claims examiner; therefore, an incorrect code may result in denial of your claim.

✓ **Don't Forget to Include the Authorization Number**

Always be sure to include on the claim the authorization number obtained from NIA. If the billed services involve more than one authorization, please be sure to list all applicable authorization numbers and specify which billing dates pertain to each authorization.

✓ **Don't Reduce Your Charge by the Co-Payment or Co-Insurance Amounts Paid by the Member**

Always show your full charge on the claim. The amount that is reimbursed is based on the lesser of the billed charge or the applicable fee schedule.

Most Frequent Reasons for Claims Non-payment

For your reference, the most frequent NIA edits, or reasons for claims denial, include:

- Duplicate claim submission (i.e., the expense was previously considered)
- No pre-authorization was obtained by the provider
- The member is ineligible, or coverage has lapsed
- Non-timely claim submission/filing
- Additional information is needed from the primary insurance carrier's Explanation of Benefits (EOB) or from the member's Coordination of Benefits (COB) form
- The claim includes a non-covered procedure/service.

Options for Submitting Electronic Transactions to NIA

Please evaluate and take advantage of one of the electronic methods available to you for submitting your claims quickly and easily. All of Magellan/NIA's claims tools are designed to save you time and eliminate paperwork burden while supporting accurate, timely claims payment.

1. Claims Courier

Accessible via the NIA Web site, Claims Courier is a Web-based data entry application for providers/facilities submitting professional claims on a claim-at-a-time basis. You can gain access to Claims Courier by signing onto the site with your username and password, and following the instructions for "Submit a Claim Online." Claims Courier streamlines the claims process by eliminating the claims middleman, and there is no charge to you for using the service. You simply enter your claims information into the online Claims Courier application. Note that Magellan must be the designated payer in order to process your submitted claims. On the main Claims Courier (Submit a Claim) page, you can:

- Create a new, blank claim;
- Create a new claim from a copy of a previously submitted claim;
- Complete a claim you saved previously; and
- View your submitted claims.

2. Direct Submit

Through this NIA application, HIPAA-compliant 837 files can be sent directly to NIA in bulk, without accompanying claim data entry or the involvement of a clearinghouse. Direct Submit is available to all providers regardless of claims submission volume. There is no charge to you for using the service.

To get started on the process, visit our EDI Testing Center Web site at www.edi.MagellanProvider.com. The center offers an easy-to-follow, six-step process to independently validate your EDI test files (837 Professional and Institutional) for HIPAA compliance rules and codes. You will be assigned an IT analyst to guide you through the process and address any questions. The process includes creating your unique user ID and password, downloading EDI guideline documentation (companion guides), uploading and testing EDI files, and obtaining immediate feedback regarding the results of the validation test. Once you have completed the six-step process, you will be able to exchange production-ready EDI files with NIA.

You can register to submit EDI claims to NIA by sending an e-mail to EDISupport@MagellanHealth.com or by contacting Magellan EDI Support at 1-800-450-7281, extension 75890.

3. Clearinghouses

External EDI clearinghouses act as a middleman between the provider and NIA, and can transform non-HIPAA-compliant formats to compliant 837s. NIA accepts 837 transactions from a number of clearinghouses; review the clearinghouse contacts on the following page. Note that there may be charges from the clearinghouses.

Approved Clearinghouse Contact Information

Payerpath (formerly Mysis and also known as Allscripts)
9030 Stony Point Pkwy.
Suite 440
Richmond, VA 23235
1-877-623-5706
www.payerpath.com

Capario (formerly MedAvant and ProxyMed)
1901 E Alton Ave, Suite 100
Santa Ana, CA 92705
1-800-586-6938
PayerAdvocacy@Capario.com

AVAILITY (formerly THIN)
P.O. Box 550857
Jacksonville, FL 32255-0857
1-800-282-4548
www.availity.com

Emdeon Business Services (formerly WebMD)
One Century Place
26 Century Blvd, Suite 601
Nashville, TN 37214
1-615-885-3700
http://transact.emdeon.com

NaviNet Claims (also known as AmpMed Corporation)
4001 Office Court Drive
Building 200
Santa Fe, NM 87507
1-800-526-7276
Fax: 505-982-3904
www.navinetclaims.com

RelayHealth (also known as McKesson)
700 Locust Street
Suite 500
Dubuque, IA 52001
1-800-527-8133, Option 2
www.relayhealth.com

Gateway EDI, Inc.
One Financial Plaza
501 North Broadway, 3rd Floor
St. Louis, MO 63102
1-800-969-3666
www.gatewayedi.com

NOTE: You can also submit electronic claims to a non-approved clearinghouse as long as your clearinghouse contacts one of the NIA approved clearinghouses to arrange to transmit the claims.

When using the services of a clearinghouse, it is critical that the proper Payer ID is used so the EDI claims are sent to NIA.

- The following Payer IDs are required for all clearinghouses **with the exception of Emdeon:**

  837P (Professional) – NIA11
  837I (Institutional) – NIA 11

- The following unique Payer IDs are for **Emdeon only**:

  837P (Professional) – SX190
  837I (Institutional) – 12X55

Elements of a Clean Claim

1. **Clean claim defined.** A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment. A provider submits a clean claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements, or revisions to data elements, attachments and additional elements, of which the provider has knowledge. Claims for inpatient and facility programs and services are to be submitted on the UB-04 and claims for individual professional procedures and services are to be submitted on the CMS-1500. In addition, claims may be submitted electronically through a contracted clearinghouse or on NIA's Web-based claims submission application. NIA does not typically, but may require attachments or other information in addition to these standard forms (as noted below). NIA may request treatment records for review.

2. **Required clean claim elements.** The Center for Medicare and Medicaid Services (CMS) developed claim forms that record the information needed to process and generate provider reimbursement. The CMS-1500 form (revised August 2005 version) is for use by outpatient providers such as physicians, radiologists and other non-institutional providers. The required elements of a clean claim must be complete, legible and accurate.

CMS-1500

In the following line item description, the parenthetical information following each term is a reference to the field number to which that term corresponds on the CMS-1500 claim form.

- Subscriber's/patient's plan ID number (field 1a);
- Patient's name (field 2);
- Patient's date of birth and gender (field 3);
- Subscriber's name (field 4);
- Patient's address (street or P.O. Box, city, zip) (field 5);
- Patient's relationship to subscriber (field 6);
- Subscriber's address (street or P.O. Box, City, Zip Code) (field 7);
- Whether patient's condition is related to employment, auto accident, or other accident (field 10);
- Subscriber's policy number (field 11);
- Subscriber's birth date and gender (field 11a);
- HMO or preferred provider carrier name (field 11c);
- Disclosure of any other health benefit plans (field 11d);
- Patient's or authorized person's signature or notation that the signature is on file with the physician or provider (field 12);

- Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (field 13);
- Date of current illness, injury, or pregnancy (field 14);
- First date of previous, same or similar illness (field 15);
- Name of Referring Provider or Other Source (field 17);
- Referring Provider NPI Number (field 17b);
- Diagnosis codes or nature of illness or injury (current ICD-9 codes are required) (field 21);
- Date(s) of service (field 24A);
- Place of service codes (field 24B);
- EMG (field 24C);
- Procedure/modifier code (current CPT or HCPCS codes are required) (field 24D);
- Diagnosis code (ICD-9) by specific service (field 24E);
- Charge for each listed service (field 24F);
- Number of days or units (field 24G);
- Rendering provider NPI (field 24J);
- Physician's or provider's federal taxpayer ID number (field 25);
- Total charge (field 28);
- Signature of physician or provider that rendered service, including indication of professional license (e.g., MD, LCSW, etc.) or notation that the signature is on file with the HMO or preferred provider carrier (field 31);
- Name and address of facility where services rendered (if other than home or office) (field 32);
- The service facility Type 1 NPI (if different from main or billing NPI) (field 32a);
- Physician's or provider's billing name and address (field 33); and
- Main or billing Type 1 NPI number (field 33a).

UB-04

The UB-04 form (previously known as the UB-92 and CMS-1450 claim forms) captures essential data elements for providers of services in institutional/inpatient/facility settings. The form can be used to bill Medicare fiscal intermediaries, Medicaid state agencies and health plans/insurers. The required elements of a clean claim must be complete, legible and accurate.

In the following line item description, the parenthetical information following each term is a reference to the field number to which that term corresponds on the UB-04 claim form.

- Provider's name, address and telephone number (field 1);
- Patient control number (field 3);
- Type of bill code (field 4);

- Provider's federal tax ID number (field 5);
- Statement period (beginning and ending date of claim period) (field 6);
- Patient's name (field 8);
- Patient's address (field 9);
- Patient's date of birth (field 10);
- Patient's gender (field 11);
- Date of admission (field 12);
- Admission hour (field 13);
- Type of admission (e.g. emergency, urgent, elective, newborn) (field 14);
- Source of admission code (field 15);
- Patient-status-at-discharge code (field 17);
- Value code and amounts (fields 39-41);
- Revenue code (field 42);
- Revenue/service description (field 43);
- HCPCS/Rates (current CPT or HCPCS codes are required) (field 44);
- Service date (field 45), (required for each date of facility-based non-inpatient services or itemization in a separate attachment is required);
- Units of service (field 46);
- Total charge (field 47);
- HMO or preferred provider carrier name (field 50);
- Type 2 main NPI number (field 56);
- Subscriber's name (field 58);
- Patient's relationship to subscriber (field 59);
- Insured's Unique ID (field 60);
- Principal diagnosis code (current ICD-9 codes are required) (field 67);
- Rendering provider Type 1 NPI (field 76-79); and
- Attending physician ID (field 76-79).

3. **Data elements.** Unless otherwise agreed by contract, the data elements contained in this paragraph are necessary for claims filed by physicians or providers if circumstances exist which render the data elements applicable to the specific claim being filed. The applicability of any given data element contained in this paragraph is determined by the situation from which the claim arose.

   (1) Other insured's or enrollee's name (CMS-1500, field 9), is applicable if patient is covered by more than one health benefit plan. If the essential data element specified in CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.
   (2) Other insured's or enrollee's policy/group number (CMS-1500, field 9a), is applicable if patient is covered by more than one health benefit plan. If the essential data element specified in paragraph CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.

(3) Other insured or enrollee date of birth (CMS-1500, field 9b), is applicable if patient is covered by more than one health benefit plan. If the essential data element specified in paragraph CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.

(4) Other insured or enrollee plan name (employer, school, etc.) (CMS-1500, field 9c), is applicable if patient is covered by more than one health benefit plan. If the essential data element specified in CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.

(5) Other insured or enrollee HMO or insurer name. If the essential data element specified in CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.

(6) Subscriber's plan name (employer, school, etc.) (CMS-1500, field 11b) is applicable if the health benefit plan is a group plan;

(7) Prior authorization number (CMS-1500, field 23), is applicable when prior authorization is required;

(8) Whether assignment was accepted (CMS-1500, field 27), is applicable when assignment has been accepted;

(9) Amount paid (CMS-1500, field 29), is applicable if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a primary plan (Commercial or Medicare). When applicable, a copy of the primary plan's EOB is required;

(10) Balance due (CMS-1500, field 30), is applicable if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber;

(11) Discharge hour (UB-04, field 16), is applicable if the patient was an inpatient, or was admitted for outpatient observation;

(12) Condition codes (UB-04, fields 18-28 are applicable if the CMS UB-04 manual contains a condition code appropriate to the patient's condition;

(13) Occurrence codes and dates (UB-04, fields 31-34), are applicable if the CMS UB-04 manual contains an occurrence code appropriate to the patient's condition;

(14) Occurrence span code, from and through dates (UB-04, field 36), is applicable if the CMS UB-04 manual contains an occurrence span code appropriate to the patient's condition;

(15) HCPCS/Rates (UB-04, field 44), is applicable if Revenue Code description used does not adequately describe service provided or if Medicare is a primary or secondary payer;

(16) Prior payments – payer and patient (UB-04, field 54), is applicable if payments have been made to the physician or provider by the patient or another payer or subscriber, on behalf of the patient or subscriber, or by a primary plan;

(17) Diagnoses codes other than principle diagnosis code (UB-04, fields 67), is applicable if there are diagnoses other than the principle diagnosis and ICD-9 code is required;

(18) Ambulance trip report, is applicable for itemizing a covered ambulance service; and

(19) Anesthesia report is applicable to report time spent on anesthesia services.

4. **Additional clean claim elements**. In the event information not specified herein is required to make an accurate determination of proof of loss, the provider will be notified in writing within the applicable regulatory or contractual prompt payment standards. The notice will identify the specific claim or portion of a claim that is being reviewed and the information required. The review is completed within the applicable prompt payment standard following receipt of the information requested from the provider.

Coordination of Benefits

NIA coordinates benefits with other payers when a member is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a member is covered by more than one health benefit plan. It is a contractual provision of a majority of health benefit contracts. NIA complies with federal and state regulations for COB and follows COB guidelines published by the National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. NIA's Claims COB and Recovery Unit procedures are designed to avoid payments in excess of allowable expenses while also making sure claims are processed both accurately and timely.

Unless specifically mandated by state law or a client contract, NIA does not coordinate benefits with individual contracts (including private indemnity plans), Medicaid, TriCare, school sponsored plans, or disease specific policies not providing benefits on an expense incurred basis.

Identifying Primary and Secondary Liability

NIA uses NAIC rules for determining primary and secondary benefit plans. The most common rules for determining the order of payment are the Non-dependent/Dependent Rule, Active/ Inactive Rule and Birthday Rule.

- **Non-dependent/Dependent Rule:** The first rule governing the order of benefit determination is that the plan covers the individual as an employee, member or subscriber before plan benefits in which the individual is considered a dependent.

- **Active/Inactive Rule:** A policy that covers an individual as an active employee is the primary payer over the policy covering the individual as a retired or laid off employee. This rule also applies to dependents covered under two policies.

- **Birthday Rule:** This is a method used to determine when a plan is primary or secondary for a dependent child when covered by both parents' benefit plan. The parent whose birthday (**month and day only**) falls first in a calendar year is the parent with the primary coverage for the dependent. If both parents have the same birthday, then the plan that has been in effect the longest pays as primary. NIA follows this birthday rule unless a contract specifically requires otherwise.

For more information on NAIC rules, visit the NAIC Web site at http://www.NAIC.org.

When Medicaid is a payer, it is always the payer of last resort. Similar rules apply to Medicare subscribers. For more information on COB with Medicaid and/or Medicare subscribers, please refer to the CMS Web site at: http://www.cms.hhs.gov/home/medicare.asp.

COB Procedures

During benefit enrollment or whenever there is a change in coverage, the member is required to provide information to each carrier if s/he has more than one benefit carrier. To facilitate prompt claims processing, this information must be forwarded to NIA along with other essential eligibility information. By verifying eligibility information prior to seeing members, providers help make sure that benefit updates and changes are completed thereby avoiding claims processing delays. There are specific boxes on all claims forms that request coordination of benefits information.

When any of the following circumstances exist, NIA generally investigates the possibility of primary coverage and other party liability (OPL) prior to paying the claim.

- An Explanation of Benefits (EOB) from another health insurance carrier is attached to the claim.

- Other insurance information is printed in Box 9A-D on the CMS-1500 claim form.

- Box 11D on the CMS-1500 is checked "yes."

- Box 29 on the CMS-1500 indicates that a payment has already been made to the provider by a source other than NIA.

- Box 50 and Boxes 58-61 on the UB-04 claim form indicate other insurance information.

- Any information on the claim or attached to the claim indicates the possibility of other insurance. (Example: copy of an insurance card from another carrier, or letter from another insurance company.)

- The claimant is 65 years of age or older.

- COB information is on file for other family members.

- The member's last name is different from the subscriber(s) listed on the claim.

Specific health plan contractual arrangements or state regulatory requirements may require that NIA pay the claim first and then investigate the possibility of dual coverage. In most instances, however, NIA will attempt to contact the member to clarify the situation prior to paying the claim. Claims falling within this description are considered "unclean" and are not subject to most prompt payment laws until the issue has been resolved. In these cases, providers and members are notified in writing that the claim will remain unpaid until further

information is received from the member, and that if payment and/or nonpayment notice is not received within 120 days of the date of the EOB/EOP, then they may pursue payment from the primary carrier or the member.

Appendix B
Payor Participation Schedule

Payor Participation Schedule

- AMERIGROUP Community Care
- Amerihealth Mercy
- Arise Health Plan
- Arkansas Blue Cross Blue Shield
- Avmed
- Blue Cross Blue Shield of Florida
- Blue Cross Blue Shield of South Carolina
- BlueChoice of South Carolina
- Blue Shield of California
- Capital Blue Cross
- CareSource
- Centene - Absolute Total Care, Buckeye Community Health Plan, IlliniCare, Magnolia Health Plan, Peach State Health Plan, Superior Health Plan and Sunshine Health Plan.
- CIGNA (Ohio, Illinois, Georgia and St. Louis)
- Connecticare
- Coventry – Coventry Health Care of Florida, Group Health Plan, HealthAmerica of Pennsylvania, PersonalCare, Southern Health, WellPath
- Dean Health Plan
- Gateway Health Plan
- Geisinger Health Plan
- Harvard Pilgrim Health Care
- HealthNow New York
- Highmark
- Highmark West Virginia (formally Mountain State)
- HMSA Blue Cross Blue Shield of Hawaii
- Horizon New Jersey Health
- Independent Health
- Keystone Mercy
- Network Health Plan
- PA Medical Assistance
- Principal Financial Group
- Tufts Health Plan
- Windsor

Appendix C
Frequently Asked Questions

Frequently Asked Questions

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

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 serve 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 are included in this handbook. 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 process include?

The credentialing process includes:

- **Administrative Verification** – We verify the provider's or facility's licensure, accreditation, insurance, malpractice history, and Medicaid/Medicare sanctions history, in addition to the other criteria stated in Appendix A of this handbook.
- **Committee Review** - If your facility's credentials satisfy NIA's standards, your facility's application is sent to the NIA Credentialing Committee consisting of NIA clinical staff 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 <u>not</u> 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 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 and the NIA Credentialing Committee reviews your facility's re-credentialing application subject to applicable state laws and business needs. If your facility's programs and services match our service needs in your area, your facility will be re-credentialed to continue as an NIA provider.

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

How do I obtain prior authorization?

When prior authorization is required, the referring provider must secure the authorization through www.RadMD.com or call NIA before the study is conducted for non-urgent services.

What do I do for an after business hours or holiday pre-authorization need?

Most benefit plans have a 24-hour access number. If the plan does not have 24-hour access and asks you to call on the next business day, document the phone number you called, the date, time of day, a description of the voice message received and the name of the person calling for authorization, then place another call on the next business day.

Can a facility access information on an approved authorization?

Yes, approved authorizations can be viewed on www.RadMD.com. On the right side of the home page is a section where the facility may log on and then check the status of authorizations on 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.

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).

Can a rendering facility obtain an authorization?

In the event of an urgent test, a rendering provider may initiate the authorization, but NIA will contact the ordering physician to authenticate the referral and obtain the necessary clinical information.

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 health plan customer.

Which PET scans require prior authorization?

<u>All</u> outpatient PET scans require authorization by NIA.

What happens if a patient is authorized for a CT of the head, and the radiologist or rendering physician feels an additional study of the neck is needed?

The radiologist or rendering physician should attempt to obtain authorization by calling the number on the member's benefit card. If that is not possible due to scheduling or member constraints, he/she should call NIA within one business day of the administration of the additional test. A post-service test request will be reviewed to determine whether 1) medical necessity was met and/or 2) the circumstances that resulted in not being able to get pre-authorization were warranted. This procedure may vary depending on individual health plan policies.

What is the appeals process?

Because the appeal process varies depending on customer requirements and state laws, available appeal options are outlined in the non-authorization letter to the provider.

Electronic Claims Submission (This section applies to NIA health plan customers who delegate claims processing/payment to NIA)

Does NIA accept electronic claims submission?

For customers who delegate claims processing and payment to NIA, NIA accepts electronic claims submissions for services normally submitted on a Form CMS-1500 and for institutional claims (normally submitted on a UB-04). We also have contracts with several clearinghouses to facilitate electronic transactions, including claims processing for most accounts for which NIA is the contracted claims payer.

How can I submit electronic claims to NIA?

NIA providers have several options for submitting electronic claims.

- **A Web-based direct data entry claim submission tool (Claims Courier) on RadMD.com**. Professional claims typically submitted on a CMS-1500 form can be submitted through our Web site. On the NIA Web site after login, go to My Claims where you can use the Submit a Claim Online application.

- **Direct Submit with NIA**. If you are able to transmit data in a HIPAA-compliant 837 format, submit claims directly to NIA through a direct-submit upload process. Information about this process is available after login on www.RadMD.com.

- **Contracted Clearinghouses**. If your claims volume is large enough to make direct data entry cumbersome, or if claims for your services must be submitted on an institutional claim (UB-04), we encourage you to consider working with one of our preferred clearinghouses listed in Appendix B. If you already work with a clearinghouse, by advising them of the clearinghouses NIA works with, your clearinghouse will likely be able to have your claims routed to us for payment.

Will I be charged a fee to submit my claims electronically?

NIA will not charge a fee for electronic claims submitted through our Web-based submission tools. However, our contracted clearinghouses do charge fees based on your ability to submit a HIPAA-compliant (X12) transaction. The fees charged by these clearinghouses are in addition to fees NIA absorbs for each EDI transaction.

Are there HIPAA-compliant billing code requirements for electronic claims submissions?

Yes. All electronic claims submissions must include HIPAA-compliant billing codes (ICD-9-CM codes) in order to be processed.

What if I already use a clearinghouse and it's not the same as the clearinghouses that NIA is using?

In order to submit electronic claims to NIA, your clearinghouse would need to contact one of the NIA clearinghouses to arrange to transmit the claims.

Can a facility or provider practice of any size file electronic claims?

Yes.

What do I need to do to file a claim electronically with NIA?

To file a claim using NIA's Web-based direct data entry claim submission application, Claims Courier, you will need to log in to the provider page on www.RadMD.com with your username and password. If you have never logged on to a NIA provider Web site before, click on the New User link in the Sign-in box and follow the instructions on your screen to set up a username and password.

To file an electronic claim through a clearinghouse, you or your clearinghouse must contact one of the clearinghouses with which NIA has arranged to receive electronic claims and arrange for your claims to be submitted to NIA.

What should I do if my claim is rejected for payment?

Be sure to thoroughly read any rejection notices you receive. If, after reading the rejection notice you have questions, call the claims phone number on the notice for further clarification. Often the same error is submitted repeatedly resulting in repeated rejections. After reviewing the rejection notice, the claim should be corrected and re-submitted.

What should I do if I receive a notice that my claim was accepted but then don't receive payment?

If you receive a notice that NIA accepted your claim, you can check the status of your claim through the Claims Inquiry application after logging onto the NIA provider Web site.

Do not re-submit the claim as this will result in a claim denied as a duplicate and you may be subject to unnecessary clearinghouse charges.