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# Physical Medicine Prior Authorization Program Quick Reference Guide

**April 2024**

HMSA's Physical Medicine Program requires prior authorization for outpatient rehabilitative and habilitative physical medicine services (i.e., physical therapy, occupational therapy, and chiropractic services). This program is consistent with industrywide efforts to manage the increased use of these services and to ensure quality of care.

Chiropractic services require prior authorization for commercial plan members only.

## Prior Authorization

Providers must request prior authorization for the physical medicine procedures listed below within 10 business days of the requested start date. The 10-business-day provision started Feb. 1, 2023.

Evolent manages the following nonemergency procedures and conducts medical necessity reviews of requested services only.

| | |
|---|---|
| **Services that require authorization** | Outpatient services for:<br>• Physical therapy.<br>• Occupational therapy.<br>• Chiropractic services for commercial plan members. Services for HMSA Akamai Advantage® plan members don't require authorization. Chiropractic services aren't a benefit of QUEST Integration.<br>FEP members are excluded from this program. |
| **The review is focused on therapy services performed in the following settings** | • Outpatient office.<br>• Outpatient hospital. |

Therapy provided in hospital emergency rooms, inpatient and observation status, acute rehab hospital inpatient, home health, and inpatient and outpatient skilled nursing facilities are excluded from this program.

In addition:

- Any initial evaluation and treatment CPT codes submitted for physical medicine services for the initial date of service don't require prior authorization. Services rendered after the initial date of service require prior authorization with the exception of occupational and chiropractic services as listed below.
- The policy on the number of occupational therapy and chiropractic services will remain the same (i.e., eight unmanaged visits per discipline, per member, per calendar year). Providers must request prior authorization once the unmanaged visits have been exhausted and before further treatment sessions. Before rendering services, providers should ensure the patient hasn't exhausted eight unmanaged visits for the calendar year through their own practice or other providers.
- Similar to Tier A under the program that ended Dec. 31, 2022, providers may be granted a Fast Pass for physical therapy services based on their performance. Fast Pass providers aren't required to request prior authorization.

## Requesting Prior Authorization

- Providers are encouraged to use RadMD.com to request prior authorization. If a provider is unable to use RadMD.com, they may call 1-866-306-9729.

## Information Needed to Request Prior Authorization

To expedite the prior authorization process, please have the appropriate information ready before logging in to RadMD.com or calling 1-866-306-9729:

- Name, address, and TIN of the office or facility that will be used for billing the service.
- Member name, subscriber ID number, and date of birth.
- Requesting/rendering provider type: PT, OT, chiropractic.
- Name of office or facility where the service will be performed.
- Date of initial evaluation.
- ICD-10 code(s).
- Details justifying therapy:
    - Initial evaluation or reevaluation findings:
        - Medical history.
        - Patient symptoms.
        - Prior treatment received for the same condition.
        - Functional outcome/standardized test scores.
        - Baseline functional status and impairments.
        - Objective tests and measures.
        - Specific functional goals.
        - Interventions to be used.
    - Plan of care/treatment plan.

## Website Access

- Go to RadMD.com, click New User, and select Physical Medicine Practitioner to submit an application for a new account.
- To request prior authorization at RadMD.com, click Request Physical Medicine in the main menu.
- To add services to an existing authorization, use Initiate a Subsequent Request on RadMD.com.
- RadMD.com is available 24/7 except when maintenance is performed every third Thursday of the month, 6 to 9 p.m. Hawaii time.
- **Pended requests:** If you're requesting prior authorizations through RadMD.com and your request pends, you'll receive a tracking number. You'll be required to submit additional clinical information to complete the process.
- **Authorization status:** To check the status of prior authorization requests, use View Request Status in the main menu. In addition to viewing clinical documentation sent to Evolent, users can view links to case-specific communications such as requests for additional information and determination letters.
- Track an Authorization allows users who didn't originally request prior authorization to view the status of an authorization and upload clinical information. This option is also available in the main menu using Search by Tracking Number.

## Telephone Access

- Call center hours of operation are Monday through Friday, 6 a.m. to 6 p.m. Hawaii time. To request prior authorization, call Evolent at 1-866-306-9729.
- If you have questions or need more information, call the Evolent provider service line at 1-800-327-0641.
- Out-of-network providers should call Evolent to request prior authorization.

## Submitting Claims

- Continue to submit claims to HMSA as usual:
  - By EDI: Payor ID number 990040115.
  - By mail:

    HMSA
    Claims
    P.O. Box 44500
    Honolulu, HI 96804-44500

**Important Notes**

- **The authorization number or request ID** consists of alphanumeric characters. In some cases, the ordering provider may receive a tracking number if the request isn't approved at the initial contact.
- **Multiple physical medicine requests:** Evolent can accept multiple requests on RadMD.com or during one phone call.
- HMSA plan benefits limit payment to up to four modalities per day for all physical medicine services.
- **Clinical guidelines:** Evolent issues authorizations in accordance with the HMSA and Evolent Clinical Guidelines and Milliman Care Guidelines for physical medicine:
    - A link to these clinical guidelines can be found on RadMD.com under Online Tools/Clinical Guidelines.
- Evolent guidelines for physical medicine services are based on evidence-based research, generally accepted industry standards, and best practice guidelines established by the corresponding national organizations.
- **Complaints and appeals:** For prior authorization complaints and appeals, follow the instructions on your denial letter or explanation of payment.
- Once a denial determination has been made, a reconsideration can be initiated by uploading new or additional information to RadMD.com or fax it using the case-specific fax coversheet to Evolent.
- Reconsideration:
    - One reconsideration is available with new or additional information.
    - Commercial (including HMSA Federal Plan 87) and QUEST Integration plans timeframe for reconsideration is 60 calendar days from the date of denial and before submitting a formal appeal.
    - HMSA Akamai Advantage (Medicare) reconsiderations must be initiated within one year from the date of denial and before submitting a formal appeal.

- Evolent has a specialized clinical team focused on physical medicine services. Peer-to-peer discussions are available for any request that doesn't meet medical necessity guidelines. The physical medicine provider may call 1-866-306-9729 to initiate the peer-to-peer process. These discussions provide an opportunity to discuss the case and collaborate on the appropriate services for the patient based on the clinical information.
- **Patient eligibility:** To verify member eligibility, including benefit information, call HMSA Provider Services at 808-948-6330 or 1-800-790-4672. Or call the Customer Relations number on the back of the patient's HMSA membership card.
- Federal plan members are excluded from this program.

- **A prior authorization number isn't a guarantee of payment.** Authorizations are based on medical necessity and are contingent on eligibility and health plan benefits that may be subject to limitations and/or qualifications as referenced in the plan.
- **Balance billing:** Payment will be denied for physical medicine procedures performed without prior authorization. The patient cannot be balance billed for such services.

**Provider relations:** For information on Evolent's procedures, staff training, or help with provider issues or concerns, email: HMSAProviderConcerns@evolent.com.