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Physical Medicine Prior Authorization Program Frequently Asked Questions

Updated June 2025

General Questions

When does the physical medicine services program transition to Evolent (formerly Magellan Hawai`i)?

- The program was effective Jan. 1, 2023.

What are physical medicine services?

- Physical medicine services include physical therapy, occupational therapy, and chiropractic services.

What services will require prior authorization?

- Physical and occupational therapy for HMSA members in commercial, QUEST Integration, and HMSA Akamai Advantage® plans.
- Chiropractic services for commercial plans only (excluding FEP plans and complementary care benefits through American Specialty Health).

Is prior authorization required for federal plans?

- No, FEP is excluded. HMSA Federal Plan 87 is included in commercial.

Is prior authorization required for out-of-network physical medicine services?

- Yes, out-of-network providers must contact Evolent to request prior authorization for services for HMSA members.

Will prior authorization be required for the initial evaluation?

- No, initial evaluation and treatment CPT codes billed on the same initial date of service for physical medicine services don't require authorization for participating providers.
- Providers using codes outside of the standard billing CPT codes for evaluations are required to obtain prior authorization before rendering services.
- All other billed CPT codes performed after the initial evaluation date require prior authorization with the exception of providers using eight unmanaged visits as described below.
- Providers must request prior authorization for the physical medicine procedures listed below within 10 business days of the requested start date.

Have the policies changed for the eight unmanaged visits for occupational therapy and chiropractic services?

- No. Policies for unmanaged visits for occupational therapy and chiropractic services per member per calendar year will remain the same. Providers should request prior authorization once the unmanaged visits have been exhausted and before further treatment is rendered.
- Before rendering services, providers should ensure the patient hasn't exhausted eight unmanaged visits (from them or another provider) for the calendar year.

Which HMSA members are covered under this program? What networks are being used?

- Evolent manages physical and occupational therapy services for HMSA members.
- Chiropractic services will require authorization for commercial plans only.
- Complementary care benefits through American Specialty Health are excluded from this program.
- Evolent manages physical medicine services through HMSA's network of physical therapists, occupational therapists, and chiropractors.

Is prior authorization necessary for physical medicine services if HMSA is NOT the member's primary insurance?

- Yes, prior authorization is required if HMSA is the secondary plan to another non-HMSA plan.
- If the patient has more than one HMSA plan, then only ONE prior authorization is needed under their primary plan.

Exception:

- If Medicare Part B is the primary insurer, NO prior authorization is needed.

Should providers request two prior authorizations for patients who have more than one HMSA plan?

- If a patient has more than one HMSA plan, only one authorization is needed under their primary plan.

What services are included in this program?

- All physical medicine services are included in this program in the following settings:
    - Outpatient office.
    - Outpatient hospital.
    - Outpatient services performed in a member's home.

Which services are excluded from this program?

The rendering provider should continue to follow HMSA's policies and procedures for services performed in these settings:

- Therapy provided in hospital ERs.
- Inpatient and observation status.
- Acute rehab hospital inpatient.
- Home health.
- Inpatient and outpatient skilled nursing facilities.

Why does HMSA have a utilization management program for these services?

- This program promotes evidence-based and cost-effective physical services for HMSA members.

How are types of therapies defined?

- **Rehabilitative therapy:** A type of treatment or service that helps patients regain a skill or function that was lost as a result of illness or injury.
- **Habilitative therapy:** A type of treatment or service that helps patients develop skills or functions that they didn't have and are incapable of developing on their own. This type of treatment tends to be common for pediatric patients who haven't developed certain age-appropriate skills.
- Not all plans (e.g., grandfathered commercial plans) have habilitative benefits.
- The simplest way to distinguish between the two is habilitative is treatment for skills/functions that the patient never had, while rehabilitative is treatment for skills/functions that the patient had but lost.
- **Neurological rehabilitative therapy:** A supervised program of formal training to restore function to patients who have a neurodegenerative disease, spinal cord injury, or traumatic brain injury, or have had a stroke.

Is the Tier A or Fast Pass program still effective?

- New Fast Pass criteria went into effect August 1, 2024 in combination with the Therapy Provider Analytics tools.
    - Analytics tools and Fast Pass status letters were provided every six months beginning June 2024.
- All physical therapists participating in the HMSA prior authorization program are assessed annually for inclusion or removal from the Fast Pass program beginning Aug. 1, 2025.

Prior Authorization

How will prior authorization decisions be made?

- Evolent will make medical necessity decisions based on clinical information from providers and facilities that provide physical medicine services. Decisions are made as quickly as possible from clinical documentation that's received and are rendered within state-required timelines. Peer-to-peer phone requests are available at any point during the prior authorization process.
- Clinical determinations are rendered only by clinical peer reviewers with appropriate clinical experience and similar specialty expertise as the requesting provider.

Who is responsible for obtaining prior authorization for physical medicine services?

- The physical medicine provider or facility is responsible for obtaining prior authorization. A physician order may be required for a patient to engage with the practitioner, but the provider rendering the service is ultimately responsible for obtaining the authorization based on the plan of care they establish. Determination letters are sent to the patient and physical medicine provider.
- HMSA contracts don't allow balance billing. Please make every effort to ensure that prior authorization has been obtained before rendering a physical medicine service.

Will CPT codes that are used to evaluate a patient require prior authorization?

- No, initial evaluation and treatment CPT codes submitted for the initial date of service for physical medicine services don't require prior authorization.

How will providers and office staff request authorization for a physical medicine service?

- Request prior authorization either online or on the phone:
    - RadMD.com (preferred method).
    - Phone at 1 (866) 306-9729.
- The requestor will be asked to provide general provider and patient information and answer some basic questions about the patient's function and treatment plan. Based on the answers, a set of services may be offered immediately. If Evolent isn't able to offer immediate approval for services or the provider doesn't accept the services offered, additional clinical information may be required.

What is RadMD.com?

- RadMD.com is a user-friendly, real-time web-based tool from Evolent that enables ordering and rendering providers to request prior authorization quickly and easily. Whether requesting authorization or checking the status of a request, providers will find RadMD.com to be an efficient, easy-to-navigate resource.

What kind of response time can providers expect for prior authorization of physical medicine requests?

- Evolent uses a clinical algorithm to help clinician reviewers make real-time decisions at the time of the request.
- If Evolent can't offer immediate approval, the turnaround time for a determination is generally two to three business days after receiving sufficient information. Cases may take longer if additional information is needed.

Who are the "ordering/treating provider" and "clinic"?

- The ordering/treating provider is the therapist who's treating the patient and is performing the initial therapy evaluation. The clinic should also be the treating provider and their treatment location.
- You'll be required to list the treating provider and the rendering facility when requesting prior authorization on RadMD.com. If you aren't using RadMD.com, please have the information available when you call to make your request.

Can multiple providers render physical medicine services to patients if their name isn't on the authorization?

- Yes, the authorization is linked between the patient's subscriber ID number and the facility's TIN. If the providers work under the same TIN and are of the same discipline, they can use the same authorization to treat the patient.

If the servicing provider fails to obtain prior authorization for the procedure, will the patient be held responsible?

- No. This prior authorization program won't result in any additional financial responsibility for a patient using a participating provider regardless of authorization. The participating provider may be unable to obtain reimbursement if prior authorization isn't obtained; the patient's responsibility is determined by plan benefits.
- If a procedure isn't authorized and rendered by an HMSA participating provider, benefits will be denied, and the patient won't be responsible for payment.

How do I send required clinical information to Evolent?

- The most efficient way to send clinical information is to upload the documents to RadMD.com. Information can be uploaded immediately after requesting authorization. Using the upload feature expedites your request since it's automatically attached and forwarded to our clinicians for review.
- If uploading isn't an option for your practice, you may fax using the Evolent-specific fax coversheet. To ensure prompt receipt of your information:
    - Use the Evolent fax coversheet as the first page of your submission. Don't use your own fax coversheet since it won't contain the case-specific information needed to process the case and may delay a response.
    - Make sure the tracking number on the fax coversheet matches the tracking number for your request.

- Send each case separately with its own fax coversheet.
- Physical medicine practitioners may print the fax coversheet from RadMD.com or call Evolent at 1 (866) 306-9729 to request a fax coversheet online or during the initial phone call.
- Evolent may fax this coversheet to the physical medicine provider during authorization intake or at any time during the review process.

What information do I need when requesting prior authorization?

- Member name and date of birth.
- HMSA subscriber ID number.
- Diagnosis(es) being treated (ICD-10 code).
- Requesting/rendering provider type: PT, OT, chiropractic.
- Date of the initial evaluation at their facility.
- Type of therapy: Habilitative, rehabilitative, neurorehabilitative.
- Surgery date and procedure performed (if applicable).
- Date the symptoms started.
- Summary of functional deficits being addressed in therapy.
- Planned interventions (by billable grouping category) and frequency and duration for ongoing treatment.
- Number of body parts being treated and which side (i.e., right or left).
- Summary of functional deficits being addressed in therapy.

How will I confirm physical medicine benefits for a patient?

- Check HHIN+ for the patient's health plan benefits, benefit limitations, and number of visits remining for the year. You can also confirm this information through HMSA Provider Services at (808) 948-6330 or 1 (800) 790-4672.

How are visits calculated for multiple visits in one day?

- Multiple visits performed on the same day will be calculated as separate visits (i.e., group session and individual session for the same discipline occurring on the same date of service count as two visits).
- Providers should bill for services rendered. HMSA plan benefits limit payment to up to four modalities per day for all physical medicine services.

If a provider has obtained prior authorization and more visits are needed beyond the initial authorization, does the provider have to obtain a new prior authorization?

- No. Additional services on an existing authorization should **not** be submitted as a new request. If or when an authorization is nearly exhausted, additional visits may be requested as an addendum or addition to the initial authorization.
- To obtain additional services, clinical records will be required. Providers may upload records through RadMD.
- If the patient needs to be seen for a new condition or if there has been a lapse in care (more than 30 days) and care is to be resumed for a condition for which there's an expired authorization, providers should obtain a new authorization through RadMD.

What if I just need more time to use the services previously authorized?

- A 30-day extension on the validity period of an authorization is permitted and can be requested BEFORE the validity period has expired.
    - Use the Request Physical Validity Date Extension option on RadMD.
- Date extensions are subject to benefit limits that may restrict the length of time for a given condition or episode of care.

If a patient is discharged from care and receives a new prescription or the validity period ends on the existing authorization, what process should be followed?

- A new authorization will be required if a patient is discharged from care or after an authorization expires.

If a patient being treated has a new diagnosis, will a separate authorization be required?

- If a provider is in the middle of treatment and gets a therapy prescription for a different body part, the treating provider will perform a new evaluation on that body part and develop goals for treatment. If the two areas are to be treated concurrently, the request would be made as an addendum to the existing authorization using the same process as subsequent requests. Evolent will review the request and can add more visits, and the appropriate ICD-10 code(s) to the existing authorization.
- If care will discontinue on the previous area being treated and ongoing care will be solely focused on a new diagnosis, providers should request a new authorization and include the discharge summary for the previous area. A new authorization will be processed, and the previous care will be discontinued.

Could the program potentially delay services and inconvenience the patient?

- Evolent will make every attempt to process authorization requests efficiently and in a timely manner after receiving a request from a provider.

How do we handle procedures that don't require prior authorization?

- If no authorization is needed, the claims will process according to HMSA's claim processing guidelines.

Reconsideration/Re-Review/Re-Open and Appeals

Is reconsideration/re-review/re-open available for the physical medicine program if a request for prior authorization is denied?

- If a request is denied, the provider can upload new or additional information to RadMD.com or fax the information using the case-specific fax coversheet.
- One reconsideration/re-review/re-open is available with new or additional information.

- Commercial (including HMSA Fed 87) and QUEST Integration plans timeframe for reconsideration/re-review is 60 calendar days from the date of denial and before submitting a formal appeal.
- HMSA Akamai Advantage (Medicare) member denials are ineligible for re-opens unless related to clerical/administrative errors and require 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 discuss the case and collaborate on the appropriate services for the patient based on the clinical information.

Whom should a provider contact if they want to appeal a reconsidered denial?

- If the reconsideration results in denial or is unavailable, providers are asked to follow the appeal instructions on their denial letter or explanation of payment.

RadMD.com Access

What option should I select to receive access to initiate authorizations?

- Physical Medicine Practitioner at RadMD.com will allow you to request prior authorizations.

How do I apply for RadMD.com access?

- Go to RadMD.com and:
  - Click NEW USER.
  - Choose Physical Medicine Practitioner from the drop-down menu.
  - Complete the application.
  - Click Submit.
- You'll receive an email from the RadMD support team within a few hours with an approved username and a temporary passcode. Call the RadMD support team at 1 (800) 327-0641 if you don't receive a response within 72 hours.

How can providers check the status of an authorization request?

- Click View Request Status on RadMD.com's main menu.

How can I confirm what clinical information has been uploaded or faxed to Evolent?

- Select the patient's name in View Request Status in the main menu. On the Request Verification Detail page, select the appropriate link for the upload or fax.

Where can providers find their case-specific communication from Evolent?

- Click View Request Status.

What will the authorization number look like?

- You will receive a tracking number upon completion of your request.
- This number can be used to track the status of your request online or through our interactive voice response phone system through our call center.

If I didn't make the initial request for prior authorization, how can I view the status of a case or upload clinical documentation?

- Track an Authorization allows users who didn't submit the original request 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.

How can I receive notifications electronically instead of on paper?

- Evolent uses electronic communications by default, including final authorization determinations. Correspondence for each case is emailed to the person who requested the initial authorization on RadMD.
- Users will be sent an email when determinations are made.
    - No protected health information (PHI) will be in the email.
    - The email will contain a link that requires the user to log in to RadMD.com to view PHI.
- Providers who prefer paper communication will have the option to receive communications by fax by selecting the "Fax" radio button on the Phone and Fax Number page of the request.

Contact Information

Who can I contact if I need RadMD.com support?

- Email RadMDSupport@evolent.com or call 1 (800) 327-0641.
- RadMD.com is available 24/7, except when maintenance is performed every third Thursday of the month from 6 to 9 p.m. Hawaii time.

Who can I contact at Evolent for more information?

- Email: HMSAProviderConcerns@evolent.com.

Who can I contact at HMSA if I have questions or concerns?

- Call HMSA Provider Services at (808) 948-6330 or 1 (800) 790-4672.
- Providers may access the HMSA portal at hhinplus.hmsa.com/.