



HMSA

Physical Medicine Program

April 2026

How We Will Spend Our Time Together

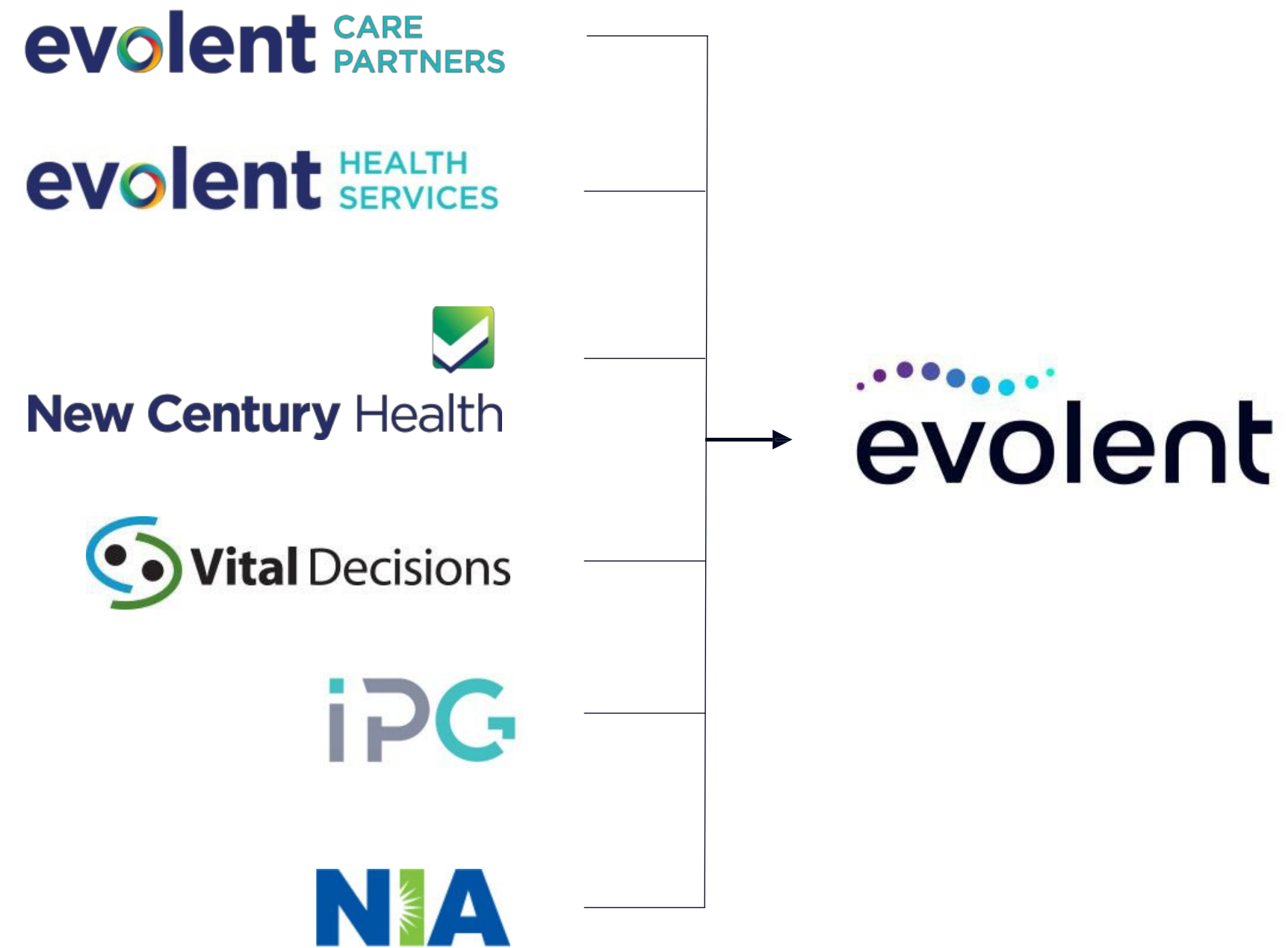
01 | Scope and Process

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NIA and New Century Health Are Now Evolent

Connecting Our Brands is About Connecting Care



Evolent | Scope and Process

High Level Partnership Responsibilities Across Entities

Evolent:

- Online portal for authorization requests
- Clinical guidelines and policies
- Review requests for medical necessity
 - Auto-approval of requests that meet criteria.
 - Medical necessity reviews
- Ordering, rendering provider and member notifications

HMSA:

- Provider contracts and credentialing
- Case management
- Claims management
- Appeals

Program Scope Overview

Additional Notes:

- Initial evaluation and treatment CPT codes submitted for the initial date of service won't require prior authorization.
- Each discipline needs a separate authorization.
- Multiple visits performed on one date of service count as separate visits.
- Benefit limit payment up to 4 modalities per day.

Service Area	Hawai'i	
Lines Of Business (LOB)	<p>Hawai'i Medical Service Association (HMSA) members under the following lines of business:</p> <ul style="list-style-type: none"> • Effective Jan. 1, 2025: Exchange • Effective Jan. 1, 2023: Medicare (Akamai Advantage), Medicaid (QUEST) and Commercial 	Backdate Grace Period
Evolut Physical Medicine Scope	<p>Services:</p> <ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy • Chiropractic Services (select commercial plans only) <p>Places of Service:</p> <p>11 - Provider office 19 - Outpatient off-campus 22 - Outpatient on-campus 62 - Outpatient Rehab Center</p>	Secondary Insurance
Authorization Process and Provider Support	<p>Ordering provider's office must submit prior authorization requests to Evolut.</p> <ul style="list-style-type: none"> • Via the Evolut RadMD provider portal at evolut.com/provider-portal • Telephonic intake, physician discussions and authorization inquiries: 1 (866) 306-9729 <p>Hours of Operation Monday - Friday, 6 a.m. – 6 p.m. Hawai'i Time</p> <p>RadMD Support RadMDSupport@Evolut.com 1 (800) 327-0641</p>	Post Adverse Determination
Evolut Turnaround Times (TAT)	<p>Commercial/Exchange: Standard Requests: 15 calendar days Expedited Requests: 72 calendar hours</p> <p>Medicaid and Medicare: Standard Requests: seven calendar days Expedited Requests: 72 calendar hours</p>	Claims and Appeals
		Evolut Resources
		Exclusions

Providers must request prior authorization for physical medicine procedures within **10 business days** from the requested authorization start date through [RadMD.com](https://www.radmd.com) or Evolut's call center. If requests are received in a timely manner, Evolut can backdate the start of the authorization to cover the requested dates of service and include any services rendered at that time.

- Beyond the 10-business day grace period, the treating provider must complete the HMSA Phys Med Retro Request Form and submit the completed form via secure email to: HMSAProviderConcerns@evolut.com
- The retro request form is available via [RADMD | HMSA](#) (Provider Resources link for HMSA)

Evolut authorization is required if HMSA is secondary to another non-HMSA insurance plan (including Medicare Advantage).

- Exceptions:**
- If Medicare Part B is the primary insurer, then NO authorization is needed.
 - If the member has more than one insurance plan with HMSA, then only ONE authorization is needed (under the member's primary HMSA plan).

A peer-to-peer discussion can be initiated once the adverse determination has been recommended. In some cases, a peer-to-peer discussion will be for consultation purposes only. A reconsideration/re-review is available with new or additional information.

- Timeframe for reconsideration/re-review is 60 calendar days from the date of denial for Commercial/Exchange (including FED87) and Medicaid (QUEST).
- Medicare (Akamai Advantage) re-opens are only allowed if they meet CMS's guidelines for a re-open.

- Providers should continue to submit their claims to HMSA, including Evolut's authorization number.
- Evolut is not delegated appeals. Appeals should be initiated through HMSA.

Resources available within Provider Resources in the Independent Health section in Evolut's [RadMD](#) portal:

- **Evolut Scope of Service:** Resource document that outlines Evolut's review scope
- Clinical guidelines, checklists and tip sheets

- All places of service not specifically listed in defined scope
- Appeals and grievances
- Claims management/provider contracting
- Lines of business outside defined scope

Summary of Changes Effective April 1, 2026

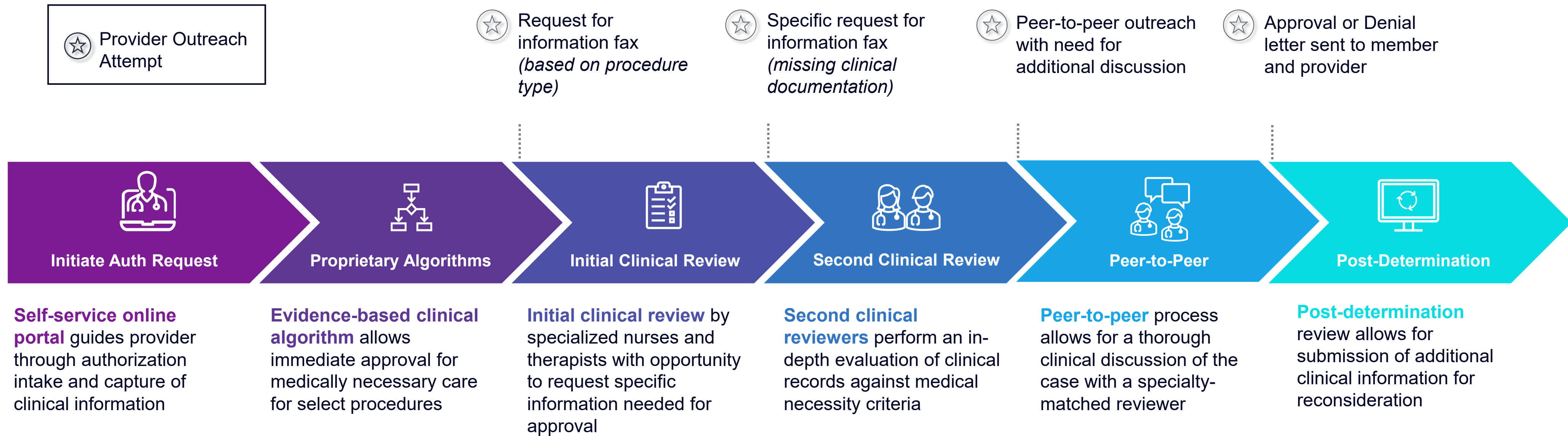
Occupational Therapy and Chiropractic Services

- **Removal of unmanaged visits:** The current allowance of eight unmanaged visits for occupational therapy and chiropractic services will be discontinued.
- **Authorization requirements:** All physical medicine services will require prior authorization through Evolent, except the initial evaluation and treatment date of service.

Physical Therapy

- **Fast Pass Program:** Please note that the current fast pass program for physical therapy will remain in place. There are no changes to fast pass eligibility or processes for physical therapy services at this time.

Prior Authorization Process



* Evolent will backdate the request if the request is submitted within **10 calendar days** from the date of service

Clinical Guidelines

- Evolent Clinical Guidelines and Milliman Care Guidelines (MCG)
- Evolent's guidelines are developed by practicing clinicians through literature reviews using evidence-based research
- All guidelines have been reviewed and approved by the Health Plan and Evolent's medical leadership
- Guidelines are available on RadMD.com

Resources and Tools

[Shared Access](#)

[Clinical Guidelines](#)

[Request access to Tax ID](#)

Physical Medicine Documentation Requirements

- **Clinical documentation is required when the request pends for review**
- Documents can be submitted via **upload on RadMD** (faster) or **fax** using an Evolent Coversheet

Rehabilitative

Initial Authorization Request:

Initial evaluation with the plan of care for clinical review.

- Information includes prior level of function as well as date of onset of current condition
- Plan of care includes frequency and duration of the request
- Goals are written in S.M.A.R.T. form (Specific, Measurable, Achievable/Attainable, and Time-bound)
- There is no open authorization at other or current facility. (Attestation Template available on RadMD.)

Subsequent Authorization Request:

- Most **recent progress note** with updated plan of care (this should include objective measures towards all goals) – Created within the past 30 days for rehabilitative care; habilitative care within 90 days
- Plus two to three recent **daily notes**
- Most **recent evaluation/re-evaluation** (if not previously submitted) and the prior evaluation for comparison

Habilitative

Habilitative Request beyond a Year of Care:

- **Re-evaluation** including start of care and progress compared to baseline measures
- Summary of prior episode(s) of care and/or therapeutic break(s)
- Information regarding additional services if being provided
- Updated standardized testing and/or functional outcome measures as applicable
- The most **recent progress note** with updated plan of care (including objective measures/data for all goals as well as any applicable changes to the plan of care)
- It may be helpful to list the date a goal was initiated and date mastered; however, this is not required
- Plus two to three of the most recent **daily notes**

Subsequent Requests

When is a subsequent request appropriate?

- After most of the previously approved visits have been used
- Need for continued skilled care
- Change in the treatment plan or plan of care
- Addition of a new diagnosis

How are subsequent requests initiated?

- Through the link on [RadMD.com](https://www.radmd.com)
- Upload or fax updated clinical documentation

When can it be initiated?

- Prior to the authorization expiring, most of the visits used, and continued skilled care is needed
- Visits build on the original authorization

Will I lose visits?

- Visits from a current authorization will not be lost and newly approved visits will be added to the original authorization

Approved Authorization

Exam Request Verification: Detail

[Upload Clinical Document](#)
[Print Fax Cover Sheet](#)
[Request Additional Visits](#)
[Request Validity Date Extension](#)

Member	Provider	Facility / Location
Name: Joey Smith Gender: Female Date of Birth: 6/7/1986 Member ID: U123456789 Health Plan: 26111 Ambetter from Peach State Secure Care - HMO FI Spoken Language: SPANISH Written Language: SPANISH	Name: Champion PT Address: 2002 Championship Drive College Park, GA 30337 Phone: (470) 987-6543 Tax ID: 987654321 UPIN: Specialty: Physical Medicine	Name: Champion PT Address: 2002 Championship Drive College Park, GA 30337 Phone: (470) 987-6543 Tax ID: 987654321

Case

Case Description: Therapy-PT **Request ID:** 98765PSH4321
Tracking: 0987654321

Request Date: 07/01/2025 04:46 PM **Status:** Approved
Entry Method: RadMD **Validity Dates:** 6/28/2025-7/28/2025

ICD10: Z43.1 [Update](#) **Contact Name:** Keith Booth
Initial Determination Date: 07/01/2025 04:46 PM **Email:** ChampionPT@email.com
Final Determination Date: 07/01/2025 04:46 PM **Extension:** No

Please be advised that all data was current as of Thursday, July 03, 2025 at 11:18 AM MST

Request ID	Visits Requested	Visits Approved	Created Date	Created User	Outcome	Updated Date	Updated User	Treatment Start	Treatment End
98765PSH4321	1	1	7/1/25 4:46PM	RadMDNotify	Approved			6/28/25 12:00AM	7/28/25 12:00AM

- **Notifications will include:**
 - Authorization Number or Request ID
 - Tracking Number
 - Visits Approved
- **Validity Period:** varies based on the number of visits approved and the plan of care
- **Modifying Authorization:**
 - Extend up to 30 days
 - Shorten the validity period

Treating an Additional Body Part

Initial Steps

- Perform a new evaluation on that body part/condition
- Develop goals for treatment

Treating body parts concurrently:

- Submit a subsequent request including:
 - Evaluation of the new body part or condition
 - Updated plan of care
 - Results of any standardized outcome measures
- Authorization will include:
 - New ICD10 code(s)
 - Additional visits as needed
 - Possibly a change to the validity period

Discontinuing care on original body part:

- Submit a new request including:
 - Discharge for the original condition or body part
 - Evaluation of the new body part or condition
 - Updated plan of care
 - Results of any standardized outcome measures
- New authorization will include:
 - Visits approved
 - New validity period
 - Original authorization will be discontinued

Partial Approvals vs Denials

Request ID	Visits Requested	Visits Approved	Created Date	Created User	Outcome	Updated Date	Updated User	Treatment Start	Treatment End
	14	3	1/9/25 11:43AM	RadMDNotify	Partially Approved	1/12/25 1:59PM			
	12		2/6/25 2:57PM	RadMDNotify	Disapproved	2/6/25 3:52PM			

Denial Rationale

- You asked for physical therapy because of chronic back pain.
- To approve this service the following criteria must be met: Evolent Clinical Guideline 605 for Measurable Progressive Improvement.
- These criteria are not met because the notes do not show why a skilled therapist is needed and that care is helping. We reviewed your therapy notes. The notes sent to us show limited change in objective measures since your last report. It is not clear how therapy is helping you. Notes do not show the care you requested is needed.

Options Following a Denial



- **Peer-to-Peer Discussion:**

- Consultation purposes only
- Scheduled by calling Evolent's call center
- *QUEST and Commercial plans:* can be initiated once an adverse determination is recommended
- *Akamai Advantage:* must be performed before a final determination has been made on the request

- **Reconsideration, Re-reviews, and Re-opens**

- *QUEST and Commercial plans:* A reconsideration/re-review is available with new or additional information. Timeframe to submit is 60 calendar days from the date of the denial.
- *Akamai Advantage* re-opens must meet CMS's guidelines for a re-open.

- **Appeals:**

- Directions to submit an appeal are included in the denial notification

Evolent | Common Reasons for Physical Medicine Denials

Common Reasons for Physical Medicine Denials

Need for Skilled Care	<ul style="list-style-type: none">• Interventions do not require the skills of a licensed therapist
Lack of Information	<ul style="list-style-type: none">• No clinical documentation received• Lacks recent objective measures or functional outcome measures
Lack of Progress	<ul style="list-style-type: none">• Minimal gains with therapy• Limited change in objective measures and improvement toward goals
Overlapping Authorizations	<ul style="list-style-type: none">• Only one authorization will be approved for providers of the same discipline, treating the same condition during the same period of time• Please submit the original clinic's discharge, contact Evolent with the member's last day of treatment, or the member can submit a signed attestation letter stating that they are only receiving care at the identified clinic as of a specified date

Common Reasons for Physical Medicine Denials

<p>Excessive Requests or Frequency</p>	<ul style="list-style-type: none">• High frequency or number of visits requested without justification• Ongoing care and documented goals are not supported
<p>Missing Key Pieces of Required Documentation</p>	<ul style="list-style-type: none">• All required documentation has not been submitted within a reasonable amount of time• A list of required documents can be found on the Physical Medicine Tip Sheet
<p>Goals and Plan of Care (Habilitative)</p>	<ul style="list-style-type: none">• Treatment goals must be realistic, measurable, functional, and promote attainment of developmental milestones commensurate to member age and circumstance
<p>Episodic Care Model (Habilitative)</p>	<ul style="list-style-type: none">• Care may be needed throughout the members lifetime, but can transition to home when the member has achieved their goals and/or functional improvement is not evident or expected to occur

When to Contact Evolent

Initiating or checking the status of an authorization request

- RadMD.com
- 1 (866) 306-9729

Initiating a peer-to-peer consultation

- 1 (866) 306-9729

Provider service line (General questions and technical RadMD issues)

- RadMDSupport@evolent.com
- 1 (800) 327-0641

Provider education requests or questions specific to Evolent

HMSAProviderConcerns@evolent.com

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