CHIROPRACTIC PROGRAM

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This chapter contains information about our network and utilization management program for chiropractic services provided to designated members.

CHIROPRACTIC PROGRAM OVERVIEW

EmblemHealth has partnered with Palladian Muscular Skeletal Health (Palladian), a specialty network and utilization management organization, to arrange chiropractic services for our members in the benefit plans listed below. Through this partnership, Palladian is responsible for the administration of prior approvals, claims payment, credentialing, recredentialing and appeals for denial determinations, as described in this chapter.

- GHI HMO
- GHI HMO - Point of Service
- GHI HMO - Senior Supplement (Commercial)
- GHI PPO
- HIP Access I and HIP Access II
- HIP Prime (HMO)
- HIP Prime (POS)
- EmblemHealth Medicare HMO
- EmblemHealth Medicare PPO
- Vytra HMO

Members and eligible dependents covered by these plans are allowed unlimited visits to a network chiropractor, based on medical necessity and the meeting of prior approval and referral requirements (according to the member's benefit).

All members excluded from the Chiropractic Program are medically managed in the same way as they are for all other services and are subject to consistent utilization review and utilization management standards and protocols.

PRIOR APPROVALS AND REFERRALS

HIP and Vytra HMO Plans

The initial visit to a chiropractor does not require prior approval. Chiropractors must obtain prior approval from Palladian for the member's second treatment, and each continued treatment thereafter, by completing and submitting the medical necessity review forms online by signing in to **www.palladianhealth.com** or by faxing them to **1-716-712-2802** for HIP members or to **1-716-712-2803** for Vytra members.

GHI HMO Plans

The practitioner providing care or the ordering specialist must provide members with a referral for them to obtain chiropractic services. This initial referral is valid for the first six visits to the participating chiropractor. Within three business days of the initial evaluation, the referred chiropractor must complete and submit the Referral Certification Form online or via fax.

To complete and submit the form for the first six visits and any additional visits thereafter, referred chiropractors may complete and submit the Referral Certification Form online after logging into **www.palladianhealth.com**. They may also fax the completed form (found at the end of this chapter) to **1-716-712-2817**. Palladian will then register the visits.

GHI PPO Plans

Members may access chiropractic care without a referral or prior approval for no less than the first eight visits, depending on the member's benefit. Chiropractors must obtain prior approval from Palladian for each continued treatment thereafter by submitting the medical necessity review forms online by logging onto **www.palladianhealth.com** or by faxing them to **1-716-712-2817**.

NOTE: Failure to submit required forms for additional authorization may result in an administrative denial.

SUBMITTING REQUESTS FOR MEDICAL REVIEW

Medical necessity determinations for future care are based on the completion of three concise clinical intake forms:

- **The Chiropractic Treatment Form** - completed by the participating therapist
- **The Chiropractic Intake Form** - completed by the patient
- **The Chiropractic Outcomes Form** - completed by the patient; or the **Pediatric Outcomes Form** - completed by the parent or guardian of patients under the age of 18

These forms are on **www.emblemhealth.com** and on **www.palladianhealth.com**. The practitioner is responsible for submitting all forms to Palladian for review. Practitioners may submit the completed forms electronically by logging onto **www.palladianhealth.com** or they may fax them to Palladian at **1-716-809-8324.**

Following are examples of the forms required for different scenarios:

- For every new patient and when there is a change in the primary diagnosis, the following three forms need to be submitted within five business days of the initial evaluation.
  - **Chiropractic Treatment Form** - completed by the therapist
  - **Chiropractic Intake Form** - completed by the patient
  - **Chiropractic Outcomes Form** - completed by the patient
- For any additional follow-up care after the initial authorization, the following two forms need to be submitted within five business days of the "Requested Start Date."
  - **Chiropractic Treatment Form** - completed by the therapist
  - **Chiropractic Outcomes Form** - completed by the patient

All requests for additional care may be submitted to **www.palladianhealth.com**.

APPEALS

For **Commercial members**, appeals for denial determinations made by Palladian must be

submitted to:

Palladian Muscular Skeletal Health
Attn: UM Department
2732 Transit Road
West Seneca, NY 14224

For **Medicare members**, appeals for denial determinations made by Palladian must be submitted to:

EmblemHealth
Grievance and Appeals Department
P.O. Box 2807
New York, NY 10116-2807

CUSTOMER SERVICE

Eligible members may call the following numbers for customer service and more information:

- HIP: **1-877-774-7693**
- GHI PPO: **1-212-501-4444** (in New York City) or **1-315-432-0826** (in all other areas)
- Medicare PPO: **1-866-557-7300**
- GHI HMO: **1-866-284-2901**
- Vytra: **1-866-883-0643**

CREDENTIALING

Palladian is responsible for the credentialing and recredentialing of participating chiropractors for GHI HMO and HIP. EmblemHealth EPO/PPO and GHI PPO providers contract directly with the plan. Please refer to the chart below:

BENEFIT PLAN	PALLADIAN	EMBLEMHEALTH
GHI HMO	Yes	
HIP	Yes	
Vytra	Yes	
EmblemHealth EPO/PPO		Yes
GHI PPO (Commercial)		Yes
Medicare Choice PPO		Yes

CLAIMS

Claims must be submitted in the following manner:

BENEFIT PLAN	ADDRESS	FORM REQUIRED
HIP and Vytra HMO	Palladian Muscular Skeletal Health P.O. Box 368 Lancaster, NY 14086-0368 For electronic claims submission, Palladian's Payor ID is 37268.	CMS-1500
GHI HMO	Palladian Muscular Skeletal Health P.O. Box 307 Lancaster, NY 14086 For electronic claims submission, Palladian's Payor ID is 37268.	CMS-1500
GHI PPO (Commercial)	GHI Claims P.O. Box 2832 New York, NY 10116	CMS-1500
Medicare Choice PPO	EmblemHealth Medicare PPO P.O. Box 2830 New York, NY 10116-2830	CMS-1500

FORMS

See the following pages for our Chiropractic Program forms:

- **Chiropractic Intake Form**
- **Chiropractic Outcomes Form**
- **Chiropractic Pediatric Outcomes Form**
- **Chiropractic Treatment Form**

Draft

DC Patient Intake Form
(version 1.1)
www.palladianhealth.com/members

Palladian

Last name | First name

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

O Neck	O Shoulder	O Hip	O Headache
O Upper/ mid back	O Elbow	O Knee	O Other
O Lower back	O Wrist	O Ankle	
	O Hand	O Foot	

2. When did this problem first begin?

O Less than 1 month ago O 1-3 months ago O 4-6 months ago O 7-12 months ago O More than 1 year ago

	Has this problem...	No	Yes
3.	... resulted from a work injury (i.e. workers' compensation insurance claim)?	O	O
4.	... resulted from a motor vehicle accident (i.e. no fault insurance claim)?	O	O
5.	... recently been evaluated by a medical doctor?	O	O
	Since this problem began, have you noticed...	**No**	**Yes**
6.	... so much weakness in both your arms that you are unable to lift them?	O	O
7.	... so much weakness in both your legs that you are unable to walk without help?	O	O
8.	... difficulty controlling your bowel or bladder, or have you been unable to urinate?	O	O
9.	... pain in your chest, shortness of breath, or coughing up blood?	O	O
10.	... that one leg felt more warm, more swollen, more red, or more tender than the other?	O	O
	Have you recently...	**No**	**Yes**
11.	... had blurred vision, double vision, dizziness, or fainting?	O	O
12.	... had any type of infection, fever, or chills?	O	O
13.	... had any type of surgery, surgical procedure, or medical procedure?	O	O
14.	... lost a lot of weight without really trying to (i.e. without being on a diet)?	O	O
15.	... had any type of accident, fall, or trauma?	O	O
	Have you ever...	**No**	**Yes**
16.	... been diagnosed with cancer?	O	O
17.	... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?	O	O
18.	... been diagnosed with a weakened immune system?	O	O
19.	... used any injected drugs (i.e. non-prescription drugs)?	O	O
20.	... used steroids such as prednisone for more than 4 weeks?	O	O
	Is this problem something that ...	**No**	**Yes**
21.	... you've had before?	O	O
22.	... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise?	O	O
23.	... generally gets better (i.e. less severe or frequent) with rest?	O	O
24.	... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?	O	O
25.	... is also being treated by a health professional other than a chiropractor?	O	O

Service Date: M M / D D / Y Y Y Y

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DC Patient Outcomes Form
(version 1.1)
www.palladianhealth.com/members

Palladian

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Last Name | First Name

1. In general, would you say your health is	Excellent	Very good	Good	Fair	Poor
The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?					
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	Yes, limited a lot	Yes, limited a little	No, not limited at all		
3. Climbing several flights of stairs					
During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?					
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4. Accomplished less than you would like					
5. Were limited in the kind of work or other activities					
During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?					
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6. Accomplished less than you would like					
7. Did work or other activities less carefully than usual					
8. During the <u>past week</u>, how much did pain interfere with your normal work (including work outside the home and housework)?	Not at all	A little bit	Moderately	Quite a bit	Extremely
These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.					
How much of the time during the <u>past week</u>...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?					
10. Did you have a lot of energy?					
11. Have you felt downhearted and depressed?					
12. During the <u>past week</u>, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now													
14. On average													
15. At its best													
16. At its worst													

Service Date: M M / D D / Y Y Y Y

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DC Pediatric Outcomes Form
(version 1.1)
www.palladianhealth.com/members

Palladian

Last Name | First Name

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. In general, would you say your child's health is

Excellent ○ | Very good ○ | Good ○ | Fair ○ | Poor ○

During the past week, has your child been limited in any of the following activities due to HEALTH problems?

2. Doing things that take some energy such as riding a bike or skating?

Yes, limited a lot ○ | Yes, limited some ○ | Yes, limited a little ○ | No, not limited ○

3. Bending, lifting, or stooping?

Yes, limited a lot ○ | Yes, limited some ○ | Yes, limited a little ○ | No, not limited ○

4. During the past week, has your child been limited in the KIND of schoolwork or activities with friends he/she could do because of PHYSICAL health problems?

Yes, limited a lot ○ | Yes, limited some ○ | Yes, limited a little ○ | No, not limited ○

5. During the past week, has your child been limited in the KIND of schoolwork or activities with friends he/she could do because of EMOTIONAL or BEHAVIORAL problems?

Yes, limited a lot ○ | Yes, limited some ○ | Yes, limited a little ○ | No, not limited ○

6. During the past week, how much bodily pain or discomfort has your child had?

None ○ | Very mild ○ | Mild ○ | Moderate ○ | Severe ○ | Very Severe ○

7. During the past week, how satisfied do you think your child has felt about his/her friendships?

Very satisfied ○ | Somewhat satisfied ○ | Neither satisfied nor dissatisfied ○ | Somewhat dissatisfied ○ | Very dissatisfied ○

8. During the past week, how satisfied do you think your child has felt about his/her life overall?

Very satisfied ○ | Somewhat satisfied ○ | Neither satisfied nor dissatisfied ○ | Somewhat dissatisfied ○ | Very dissatisfied ○

9. During the past week, how much of the time do you think your child acted bothered or upset?

All of the time ○ | Most of the time ○ | Some of the time ○ | A little of the time ○ | None of the time ○

10. Compared to other children your child's age, in general would you say his/her behavior is:

Excellent ○ | Very good ○ | Good ○ | Fair ○ | Poor ○

How would you rate the severity of your child's main health problem on a scale from 0 to 10?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
11. Right now		○	○	○	○	○	○	○	○	○	○	○	
12. On average		○	○	○	○	○	○	○	○	○	○	○	
13. At its best		○	○	○	○	○	○	○	○	○	○	○	
14. At its worst		○	○	○	○	○	○	○	○	○	○	○	

Service Date: M M / D D / Y Y Y Y

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ICD-10 Compatible

DC Treatment Form (version 2.1)
www.palladianhealth.com/providers

Palladian

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

V:PalladianDCTtreatment(2.1)20150901

Section A. Provider information

First Name
Last Name
Facility Name
Service Add.
NPI
State
Zip

Section B. Patient information

First Name
Last Name
Health Plan
Member ID

Date of (M M - D D - Y Y Y Y)
Birth
Onset
Last Visit
Requested Start

Section C. Primary region of complaint (select only 1 region) and primary diagnosis (ICD-10 number or text description)

- O Cervical
- O C/S+radiculopathy
- O Thoracic
- O Lumbosacral
- O L/S+radiculopathy

Shoulder O L O R
Elbow O L O R
Wrist O L O R
Hand O L O R
Hip O L O R
Knee O L O R
Ankle O L O R
Foot O L O R
O Headache
O Other

Authorization Request for:
- O Treatment only
- O X-ray only
- O Both

ICD-10

Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology) and X-rays

Does this patient have any red flags (e.g. "yes" answers to DC Patient Intake Form questions 6-20)? O No O Yes
Does this patient have any contraindications to receiving DC care from you for this complaint? O No O Yes
X-rays: O None O Cervical O Thoracic O Lumbar O Other X-ray CPT Code
Rule out: O Fracture O Instability O Infection O Malignancy O Systemic inflammatory disease O Other

Section E. Neurologic involvement associated with any spine condition

Which of the following symptoms or signs of neurologic involvement are present in the extremities?
Symptoms: O None O Radiating Pain O Paresthesia O Weakness
Signs: O None O Decreased sensation O Abnormal DTRs O Decreased strength O Pathologic reflex

What is the overall severity of the neurologic involvement associated with this spine condition?
O None O Very mild O Mild O Moderate O Severe O Very severe

Section F. Evaluation

Based on information provided by the patient, your examination, and your treatment history with this patient (if any), what is your evaluation of this patient's primary spine condition? Please choose one box for each of these columns.

Symptoms	Physical function	Overall health	Prognosis
O Very mild	O Very good	O Very good	O Very good
O Mild	O Good	O Good	O Good
O Moderate	O Moderate	O Moderate	O Moderate
O Severe	O Poor	O Poor	O Poor
O Very severe	O Very poor	O Very poor	O Very poor

Section G. Management plan (i.e. how you plan on managing this patient's complaint)

Education about:	O Diagnosis	O Prognosis	O Remaining active	O Other	O None
Home/self-care:	O Heat/ice	O General exercises	O Specific exercises	O Other	O None
Supervised exercise:	O Strengthening	O Stretching	O Stabilization	O Other	O None
Modalities:	O Heat/ice	O TENS/EMS	O Ultrasound	O Other	O None
Manual therapy:	O Manipulation	O Mobilization	O Soft tissue	O Other	O None

Number of DC visits used since last DC Treatment Form was submitted:
O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 O Other

Phone - - Fax - -

17761

Provider signature: X Date MM / DD / Y Y Y Y

Note: By completing and signing this form, the provider indicates that they:
1. provided all services, and 2. are a participating provider, and 3. provided all services in a credentialed practice.