EmblemHealth partners with Palladian Muscular Skeletal Health (Palladian), a specialty network and utilization management organization, to manage outpatient physical and occupational therapy (PT/OT) services for members with benefit plans underwritten by its companies Health Insurance Plan of Greater New York (HIP) and HIP Insurance Company of New York (HIPIC). Palladian is responsible for the administration of preauthorization, payment for professional claims, and appeals for denial determinations made on professional claims (excluding members with Medicare plans). In addition, Palladian is responsible for credentialing and re-credentialing of network PT/OT providers.

Palladian is also responsible for preauthorization of PT/OT services administered to eligible members at a hospital outpatient facility. However, claims payment and appeals for denial determinations of these services are handled directly by EmblemHealth.

See the Directory chapter of this Provider Manual for Customer Service and Claims contacts.

The following members, services, and benefit plans are not managed by Palladian:

- PT/OT services rendered by a podiatrist
- GHI underwritten benefit plans
- Members whose ID card indicates a primary care physician from one of the following entities:
  - HealthCare Partners (HCP)
  - Montefiore (CMO)
- Members who have not been assigned to a PCP

These members are medically managed in the same way as they are for other services by the assigned Managing Entity. Referrals and preauthorizations are managed by the Managing Entity listed on the back of the members’ ID card. You should check member ID cards at every visit, regardless of service or reason for the visit.
Palladian conducts a medical necessity review process for PT/OT services to assess the patient’s current medical condition, pain, and progression of treatment. The medical necessity review process is user-friendly and designed to gather concise information from you and your patient to help determine the appropriate course of care. The process begins after the first evaluation visit which requires neither referral nor preauthorization.

Practitioners may complete and submit the required forms listed below to Palladian via palladianhealth.com:

- PT/OT Appeals Form
- PT/OT Patient Intake Form
- PT/OT Patient Outcomes Form
- PT/OT Pediatric Outcomes Form
- PT/OT Treatment Form

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

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**Hospital Outpatient Retrospective Utilization Reviews**

Retrospective Utilization Reviews (RURs) are clinical in nature and may be requested when claims are denied for a lack of medical necessity or in situations where there is no preauthorization on file. If you receive a claim denial for hospital outpatient physical or occupational therapy from EmblemHealth, you must file a RUR with Palladian.

**Time Frame for RUR Requests**
All requests for RURs must be submitted within the time frames specified in your HIP and or HIPIC contracts. If your contract(s) does not contain language regarding a specific time frame, then the appropriate state or federal regulatory time frames apply. A determination is made and communicated within 30 days of Palladian’s receipt of the request.

**Where to Submit RUR Documentation**
All RUR requests, along with medical records and other information related to the case, should be sent to the following address:

**Palladian**  
Attn: Utilization Management Department  
2732 Transit Road  
West Seneca, NY 14224

Palladian determines medical necessity and either grants the approval or upholds the denial. If you have questions, contact Palladian’s customer service department at 877-774-7693, Monday through Friday, from 8:30 a.m. to 5 p.m. ET.

For RUR-approved services, EmblemHealth reprocesses the claim(s) for the affected date(s) of service.

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**Appeals**

**Appeals of Retrospective Utilization Reviews (RURs)**
While Palladian is responsible for Retrospective Utilization Reviews (RURs) of PT/OT services administered to eligible
members at a hospital outpatient facility, appeals for denial determination of an RUR are processed by EmblemHealth as indicated in the appropriate Dispute Resolution chapter of this Provider Manual: Medicaid/HARP; Commercial/CHPlus; or Medicare. If your request for RUR of an EmblemHealth claim for hospital outpatient PT/OT is denied, you will receive information from Palladian regarding your clinical appeal rights.

**Appeals of Denials for Professional Services – Commercial**

Appeals of denial determinations on professional services for Commercial members follow Palladian's process. If you do not agree with a decision regarding medical necessity, you may:

1. Request a peer-to-peer conversation if you have not already discussed the adverse determination with the clinical peer reviewer.

2. File a standard or expedited utilization review appeal, either written or orally, within 180 calendar days of receiving the original decision. Oral standard appeals must be followed up in writing; expedited appeals do not need to be followed up in writing.

To initiate a utilization review appeal, call Palladian's customer service department toll-free at 877-774-7693, Monday through Friday, from 8:30 a.m. to 5 p.m. ET. You may initiate a written request for an appeal by sending the request to:

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

You may submit written comments, documents, records, and other information related to the case. A clinical peer reviewer who was not involved in the original decision reviews the case. If Palladian does not change its original decision, you will receive information about your or your patient's further appeal rights. Once you have completed the first-level of the internal appeals process, you are entitled to a New York State External Appeal.

**Appeals of Denials for Professional Services – Medicaid**

Appeals of denial determinations on professional services for Medicaid members follow Palladian's process. If you do not agree with a decision regarding medical necessity, you may:

1. Request a peer-to-peer conversation if you have not already discussed the adverse determination with the clinical peer reviewer.

2. File a standard or expedited action appeal, either written or orally, within 60 business days of the date of the adverse determination letter. Oral standard action appeals must be followed up in writing; expedited action appeals do not need to be followed up in writing.

To initiate an action appeal, call Palladian's customer service department toll-free at 877-774-7693, Monday through Friday, from 8:30 a.m. to 5 p.m. ET. You may initiate a written request for an action appeal by sending the request to:

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

You may submit written comments, documents, records, and other information related to the case. A clinical peer reviewer who was not involved in the original decision reviews the case. If Palladian does not change its original decision, you will receive information about your or your patient's further appeal rights. Once you have completed the first-level of the internal action appeals process, you are entitled to a New York State External Appeal. Medicaid members may also be entitled to request a New York State Fair Hearing.

**Appeals of Denials for Professional Services – Medicare**

EmblemHealth processes appeals for denial of professional services as described in the Dispute Resolution: Medicare Members chapter of this Provider Manual.
Palladian does not manage PT/OT for **GHI PPO and GHI EPO members**. This section does not apply to Bridge Program members even when accessing providers who are only contracted with GHI.

**Non-City of New York GHI PPO – Benefits and Benefit Extensions**

They have a capped, limited benefit of 30 visits per calendar year. GHI PPO members can go out of network. GHI EPO members may only see network providers. There are no referral or preauthorization requirements for these initial 30 base benefit visits.

You may use the Benefit Extension process when a non-City of New York GHI PPO member needs more than the 30 visits which are included in their base benefit.

When GHI is the primary insurer, and you believe more than 30 PT or OT visits are needed, complete and fax the **Benefit Extensions Treatment Plan Form** to 212-967-2995.

To request an extension on the time frame to schedule authorized but not yet utilized visits, complete and fax the **Extension Request for a Current Authorization Form** to 212-967-2995.

To check the status of a request, call 800-223-9870.

**City of New York GHI PPO (Including Unions and Locals)**

City of New York GHI PPO members (including all unions and locals) have a base benefit of 16 visits per calendar year for outpatient physical therapy (PT) only, covering both office and hospital-based visits. Members can go in or out of network. After the 16 visits, Empire is responsible for the preauthorization of additional visits. To request preauthorization, call the NYC Healthline at 800-521-9574. Benefit extensions do not apply.

City of New York members do not have outpatient occupational therapy (OT) as a covered service. OT is only covered as part of home care services.