PHYSICAL AND OCCUPATIONAL THERAPY PROGRAM

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PHYSICAL AND OCCUPATIONAL THERAPY PROGRAM

This chapter contains information about our utilization management program for physical and occupational therapy provided in partnership with Palladian Muscular Skeletal Health.

OVERVIEW

EmblemHealth has partnered with Palladian Muscular Skeletal Health (Palladian), a specialty network and utilization management organization, to arrange outpatient physical and occupational therapy (PT/OT) services for our members and their eligible dependents in the benefit plans listed below. Through this partnership, Palladian is responsible for the administration of prior approvals, claims payment for professional claims and appeals for denial determinations made on professional claims.

In addition, Palladian is responsible for credentialing and re-credentialing of HIP network PT/OT providers. For PT/OT services administered to HIP members at a hospital outpatient facility, Palladian is also responsible for prior approvals after the initial visit. Claims payment and appeals for denial determinations will be handled directly by HIP.

The following plans are managed by Palladian:

- Prime HMO
- GHI HMO Plans
- HIP*access*® I and HIP*access*® II
- Prime POS
- Prime EPO/ Select EPO
- Prime PPO/ Select PPO
- Medicaid Managed Care
- EmblemHealth Child Health Plus
- EmblemHealth Medicare HMO
- Advantage Care Physicians (beginning 4/1/2017)

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

- EmblemHealth EPO/PPO
- EmblemHealth CompreHealth EPO (Retired August 1, 2018)
- EmblemHealth Medicare PPO
- GHI PPO
- Inspiris
- Medicare Cost
- Members whose ID card indicates a primary care physician from one of the following entities:
  - HealthCare Partners (HCP)
  - Montefiore (CMO)
  - Lenox Hill
- PT/OT services rendered by a podiatrist

All members excluded from the PT/OT program are medically managed in the same way as they

are for all other services. The referral and prior approval protocols for these excluded members are managed by the utilization review agent listed on the back of the members' ID card.

REFERRAL REQUIREMENTS FOR AN INITIAL VISIT

For GHI HMO Members

The initial referral is valid for the first six visits to the participating PT/OT provider. Within three business days of the initial evaluation, the referred PT/OT practitioner must submit the Referral Certification Form through **www.palladianhealth.com** or via fax to **1-716-712-2817**. Palladian will then register the initial six visits.

For HIP Members

For the initial evaluation visit, EmblemHealth's current referral process remains the same. Eligible members require a referral from their primary care physician or an ordering specialist for the initial outpatient PT/OT visit. Please keep a copy of the referral in the patient's files for your records. A copy of the referral may be printed out at the time or after it is created using the Referral inquiry functions on **www.emblemhealth.com**.

After this initial visit, the servicing practitioner or hospital outpatient clinic will need to obtain prior approval directly from Palladian for all subsequent outpatient PT/OT services.

PRIOR APPROVALS

Palladian conducts a *Medical Necessity Review Process* for all PT/OT services to assess the patient's current medical condition, pain, and progression of treatment. Practitioners and patients will be able to complete and submit the required forms via Palladian's Web site at **www.palladianhealth.com**. 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.

OUTPATIENT HOSPITAL RETROSPECTIVE UTILIZATION REVIEWS FOR HIP CLAIMS

Retrospective Utilization Reviews (RURs) are clinical in nature and may be requested when HIP claims have been denied for a lack of medical necessity or in situations where there is no prior approval on file.

Should you receive a claim denial for hospital outpatient physical or occupational therapy from HIP, 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 contract with HIP. If your contract does not contain language regarding a specific time frame, then regulatory timeframes (i.e., 45 calendar days from the date of remittance) will apply. A determination will

be made and communicated within 30 days of the request.

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

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

Palladian will determine medical necessity and either grant the approval or uphold the denial. If you have any questions, you may contact Palladian's customer service department at **1-877-774-7693**, Monday through Friday, from 8:30 am to 5 pm.

For services that receive RUR approval, HIP will reprocess the claims for the affected dates of service. We ask that you do not resubmit these claims as it may result in a duplicate claim submission and possibly delay payment.

APPEALS

If your GHI HMO claims have been denied for a lack of medical necessity or because there is no prior approval on file and you would like to dispute the denial, you do not request a RUR. You will receive information from Palladian regarding your clinical appeal rights so that you may file an appeal.

If your request for RUR of a HIP claim is denied, you will receive information from Palladian regarding your clinical appeal rights. All appeals of RURs will be processed by HIP as indicated in the appropriate Dispute Resolution section of this Provider Manual: **Medicaid**; **Commercial/CHP**; or **Medicare**. All other appeals will follow Palladian's process which follows:

The appeals process for Palladian is the same for GHI HMO and HIP members.

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 written or oral standard or expedited UR appeal or action appeal within 180 calendar days of receiving the original decision. Please note that appeals filed on behalf of Medicaid members must be filed within 90 calendar days of the date of the adverse determination letter. In addition, oral standard appeals must be followed up in writing, expedited appeals do not.

To initiate a UR or action appeal, call Palladian's customer service department toll-free at **1-877-774-7693**, Monday through Friday, from 8:30 a.m. to 5 p.m. 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, New York 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 will review the case. When 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. Medicaid members may also be entitled to request a New York State Fair Hearing.

Appeals for denial determinations made by Palladian must be submitted to:

HIP Commercial Plans	GHI HMO Plans
Palladian Muscular Skeletal Health PO Box 368 Lancaster, NY 14086-0368	Palladian Muscular Skeletal Health Attn: Utilization Management 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
PO Box 2807
New York, NY 10116-2807

CUSTOMER SERVICE

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

- GHI HMO: **1-866-284-2901**
- HIP: **1-877-774-7693** or **1-716-712-2808**

CLAIMS

For instructions on submitting claims, please see the chart below.

Benefit Plan	Address	Form Required
GHI HMO	GHI PO Box 2832 New York, NY 10116-2832	CMS-1500
HIP - Professional Providers	Palladian Muscular Skeletal Health PO Box 366 Lancaster, NY 14086	CMS-1500

	For electronic claims submission, Palladian's Payor ID is 37268.	
HIP - Outpatient Facility Providers	HIP Claims Department PO Box 2803 New York, NY 10116-2803	UB-04

GHI AND EMBLEMHEALTH EPO/PPO PLANS

PT/OT Benefits

EmblemHealth PPO/EPO and GHI plan members are not covered under the Palladian program. They have a capped, limited benefit of 30 visits per calendar year. PPO members are allowed to go out of network. EPO members may only see network providers.

There are no referral or prior approval requirements for these initial base benefit visits. If more visits are needed in a calendar year, the provider may follow the member grievance process in the Dispute Resolution for Commercial/CHP Members chapter.

City of New York (Including Unions and Locals)

City of New York members (including all unions and locals) have a base benefit of 16 visits per calendar year for outpatient physical therapy (PT) only, both office-based and hospital-based. They do not have outpatient occupational therapy (OT) as a covered service. OT is only covered as part of home care services.

Benefit Extensions

The Benefit Extension process is implemented when additional visits above the base benefit are requested and are provided for under an EmblemHealth EPO/PPO or GHI EPO/PPO member's contract.

Where EmblemHealth EPO/PPO or GHI is listed as the primary insurer, you may submit a benefit extension request from our secure Provider Web site at **www.emblemhealth.com**. Once signed in, look for the option on the left-hand navigation bar. (The member's primary insurer may also be verified through our secure site.)

You may also request a Benefit Extension Treatment Plan Form for an EmblemHealth EPO/PPO or GHI member by calling:

- EmblemHealth: **1-877-482-3625**
- GHI: **1-800-223-9870**

FORMS

EmblemHealth Benefit Extensions Treatment Plan

EmblemHealth Extension Request for a Current Authorization

PT/OT Appeals Form

PT/OT Patient Intake Form

PT/OT Patient Outcomes Form

PT/OT Pediatric Outcomes Form

PT/OT Treatment Form

Please fax completed form to:
716-809-8335

Appeals Form (version 1.0)
www.palladianhealth.com/providers

Palladian

Section A. Provider information Appeal type ○ Standard ○ Expedited

Last name | Tax ID

Section B. Patient information | Plan

Last name | Member ID

Section C. Denial information

Authorization number | Date of denial M M - D D - Y Y Y Y

Section D. Basis for appeal. (Check all that apply. Please provide any additional documentation that is needed.)

1. **Poor compliance related to…**
   - ○ patient unable to attend scheduled visits (e.g. too busy, unable to take time off work, primary caregiver at home)
   - ○ patient not performing recommended home care or home exercises (e.g. improvement only noted after visit to provider)
   - ○ difficulties communicating with patient (e.g. language, cultural, or other barriers)
2. **Recent re-injury affecting primary region of complaint…**
   - ○ continued or repeated exposure to injuring activity (e.g. unable to modify activities, unable to change nature of work)
   - ○ acute re-injury occurred on: (MM-DD-YYYY) - -
3. **Potential complicating factors…**
   - ○ patient involved in litigation related to region of complaint (e.g. worker's compensation, no-fault, personal injury)
   - ○ patient receiving benefits related to ongoing incapacity (e.g. worker's compensation, SSDI)
4. **Outcomes Form does not accurately reflect patient's health status because it…**
   - ○ underestimates the severity of patient's physical or mental health (e.g. questions 1-12 on Outcomes Form)
   - ○ underestimates the severity of patient's symptoms (e.g. questions 13-16 on Outcomes Form)
   - ○ observed clinically meaningful improvements not reflected on the Outcomes Form
5. **Diagnosis recently changed for primary region of complaint based on…**
   - ○ experience treating this patient (e.g. initial working diagnosis did not accurately reflect severity of condition)
   - ○ new diagnostic testing results obtained on: (MM-DD-YYYY) - -
6. **Patient not receiving required medical or surgical intervention…**
   - ○ patient unable or unwilling to undergo required medical or surgical procedure (e.g. medication, joint replacement)
   - ○ surgical or medical procedure scheduled on: (MM-DD-YYYY) - -
   - procedure:
7. **Patient has co-morbidities that interfere or delay expected improvements, including…**
   - ○ fear avoidance behavior that precludes performing supervised exercise therapy (e.g. unable to try exercises)
   - ○ severe anxiety or depression that interferes with supervised exercise therapy (e.g. unwilling to try exercises)
   - ○ poor healing response following injury or surgical procedure (e.g. excessive scar tissue formation)
   - ○ other regions of complaint in addition to primary region of complaint (please indicate below)
8. **Remaining symptoms or functional limitations expected to resolve completely with additional visits…**
   - ○ Not applicable ○ 1 ○ 2 ○ 3 ○ 4 ○ other

Comments: _____

Provider signature | Date of appeal

17131

PT/OT Patient Intake Form
(version 1.5)
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 Stroke rehabilitation	**Other (also indicate region)**
O Upper/ mid-back	O Elbow	O Knee	O Spinal cord rehabilitation	O Post-surgical
O Lower back	O Wrist	O Ankle	O Neurologic rehabilitation	O Fracture
	O Hand	O Foot	O Balance/coordination	O Other

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 physical or occupational therapist?	O	O

17131

V:PalladianPTOTintake(1.5)20100113

47602

PT/OT Patient Outcomes Form
(version 1.5)
www.palladianhealth.com/members

Palladian

Last Name | **First name**

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

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is	○	○	○	○	○

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?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
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	○	○	○	○	○

	Not at all	A little bit	Moderately	Quite a bit	Extremely
8. During the past week, how much did pain interfere with your normal work (including work outside the home and housework)?	○	○	○	○	○

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 past week...	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?	○	○	○	○	○

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	○	○	○	○	○

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		○	○	○	○	○	○	○	○	○	○	○	

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V:PalladianPTOToutcomes(1.5)20100112

57344

PT/OT Pediatric Outcomes Form
(version 1.5)
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		○	○	○	○	○	○	○	○	○	○	○	

57344

V:PalladianPTOTpediatric(1.5)20100203

18650

ICD-10 Compatible

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

Palladian

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

Specialty: ○ PT ○ OT

NPI

Section A. Provider information

First name
Last name
Facility name

Service Street Address

Section B. Patient information

First name
Last name
Health plan
Member ID

Date of Birth (M M - D D - Y Y Y Y)
Onset
Last visit
Requested start
Surgical/ Fracture

Section C. Primary region of complaint (select only 1 region)

Spine
○ Cervical
○ C/S+radiculopathy
○ Thoracic
○ Lumbosacral
○ L/S+radiculopathy

Upper extremity
Shoulder ○ L ○ R
Elbow ○ L ○ R
Wrist ○ L ○ R
Hand ○ L ○ R

Lower extremity
Hip ○ L ○ R
Knee ○ L ○ R
Ankle ○ L ○ R
Foot ○ L ○ R

Other (also indicate region)
○ Post-surgical
○ Fracture
○ Other

Rehabilitation
○ Stroke
○ Spinal cord
○ Neurological
○ Balance/coordination

ICD-10

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

Does this patient have any red flags (e.g. "yes" answers to PT/OT Patient Intake Form questions 6-20)? ○ No ○ Yes

Does this patient have any contraindications to receiving PT/OT care from you for this complaint? ○ No ○ Yes

Section E. 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 region of complaint? Please choose one box for each of these columns.

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

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

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

Number of PT/OT visits used since last PT/OT Treatment Form was submitted:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Other

Phone - - Fax - -

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

18650

V:PalladianPTOTtreatment(2.1)20150901

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

EmblemHealth®

EmblemHealth Benefit Extensions Treatment Plan

To be completed by the provider rendering therapy. Please print clearly or type, and complete the entire form.

Date of this request: ____ /____ /____		Fax no: 1-212-967-2995	
Patient last name:		Patient first name:	
Date of birth: ____ /____ /____	Sex: ☐ M ☐ F	Policy holder certificate no:	
Insured last name:	Insured first name:	Telephone no:	
Name of provider rendering service:		Tax ID no:	
Participating provider? ☐Y ☐ N	Office contact:	Par provider no:	
Telephone no: ( )	Fax no: ( )		
Referring physician *(full name)*:		Telephone no: ( )	
Referring physician address:			
City:		State:	ZIP code:

Medical History:

Requested service *(select one)*: ☐ PT ☐ OT ☐ ST ☐ MVA-related ☐WC-Related ☐ Allergy - For allergy treatment, injection treatment start date (month/year): _____/_____
Date of illness onset: ____ /____ /____
Positive objective findings and comorbidities:

Diagnoses (description):	Associated surgery *(for current diagnosis)*:	Date: ____ /____ /____
*ICD code(s): 1. _____	2. _____	3. _____
% improved to date: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%		
% improved from previous evaluation: _____	% improved from previous functioning before injury/illness: _____	
What is the expectation of maximum medical improvement (MMI) over time?		
Has therapy been continuous? ☐Y ☐ N	Has patient been instructed in a home exercise program? ☐Y ☐ N	
Number of visits to reach MMI: _____ From date: ____ /____ /____To date: ____ /____ /____	Prognosis:	
Start of care (this year):	Visits used to date (this year):	

***Effective October 1, 2014, EmblemHealth will support ICD-10 diagnosis codes.**

Once a total of 32 visits (including base benefit) have been authorized for a particular treatment area, additional extension requests must be accompanied by a prescription from the attending physician with frequency and duration.

Note: The patient must be eligible for coverage at the time the actual services are rendered.

EMB_PR_FRM_15037_BenExtTreatPlan 8/13

EmblemHealth®

EmblemHealth Extension Request for a Current Authorization

Please use this form to request an extension on the time frame of visits already authorized but not yet utilized. Advise your patient that he or she must be compliant with therapy.

Only one date extension will be granted. Any remaining visits after this date will be forfeited. The patient will be required to return to his or her physician for re-evaluation to determine if further therapy is needed.

Benefit extension contact numbers

Phone: **1-800-223-9870**

Fax: **1-212-967-2995**

Your office may call the Benefit Extension Department after one business day to check the status of a request.

Date of this request and direct office contact:	Name of provider rendering service and phone no: ( )	
Patient first name:	Patient last name:	
Patient date of birth: ____ /____ /____	Policy holder certificate/alt ID no:	GHI reference/authorization no:
Number of visits originally authorized: _____ From: ____ /____ /____ To: ____ /____ /____		
How many visits used within original authorization period? _____		
Reason(s) why patient was noncompliant in his or her continued therapy?		
The date you would like to extend the authorization to (one date extension is permitted for a maximum of 90 days from the original start/from date): ____ /____ /____		

EMB_PR_FRM_15037_ExtensionRequest 8/13

EmblemHealth®

EmblemHealth Benefit Extensions Treatment Plan

To be completed by the provider rendering therapy. Please print clearly or type, and complete the entire form.

Date of this request: ____ /____ /____		Fax no: 1-212-967-2995
Patient last name:		Patient first name:
Date of birth: ____ /____ /____	Sex: ☐ M ☐ F	Policy holder certificate no:
Insured last name:	Insured first name:	Telephone no:
Name of provider rendering service:		Tax ID no:
Participating provider? ☐Y ☐ N	Office contact:	Par provider no:
Telephone no: ( )	Fax no: ( )	
Referring physician *(full name)*:		Telephone no: ( )
Referring physician address:		
City:	State:	ZIP code:

Medical History:

Requested service *(select one)*: ☐ PT ☐ OT ☐ ST ☐ MVA-related ☐WC-Related ☐ Allergy - For allergy treatment, injection treatment start date (month/year): _____/_____
Date of illness onset: ____ /____ /____
Positive objective findings and comorbidities:

Diagnoses (description):	Associated surgery *(for current diagnosis)*:	Date: ____ /____ /____

*ICD code(s):	1. _____	2. _____	3. _____

% improved to date: ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%	
% improved from previous evaluation: _____	% improved from previous functioning before injury/illness: _____
What is the expectation of maximum medical improvement (MMI) over time?	
Has therapy been continuous? ☐Y ☐ N	Has patient been instructed in a home exercise program? ☐Y ☐ N
Number of visits to reach MMI: _____ From date: ____ /____ /____To date: ____ /____ /____	Prognosis:
Start of care (this year):	Visits used to date (this year):

***Effective October 1, 2014, EmblemHealth will support ICD-10 diagnosis codes.**

Once a total of 32 visits (including base benefit) have been authorized for a particular treatment area, additional extension requests must be accompanied by a prescription from the attending physician with frequency and duration.

Note: The patient must be eligible for coverage at the time the actual services are rendered.

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EmblemHealth Extension Request for a Current Authorization

Please use this form to request an extension on the time frame of visits already authorized but not yet utilized. Advise your patient that he or she must be compliant with therapy.

Only one date extension will be granted. Any remaining visits after this date will be forfeited. The patient will be required to return to his or her physician for re-evaluation to determine if further therapy is needed.

Benefit extension contact numbers

Phone: **1-800-223-9870**

Fax: **1-212-967-2995**

Your office may call the Benefit Extension Department after one business day to check the status of a request.

Date of this request and direct office contact:	Name of provider rendering service and phone no: ( )	
Patient first name:	Patient last name:	
Patient date of birth: ____ /____ /____	Policy holder certificate/alt ID no:	GHI reference/authorization no:
Number of visits originally authorized: _____ From: ____ /____ /____ To: ____ /____ /____		
How many visits used within original authorization period? _____		
Reason(s) why patient was noncompliant in his or her continued therapy?		
The date you would like to extend the authorization to (one date extension is permitted for a maximum of 90 days from the original start/from date): ____ /____ /____		

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