

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
- HIPaccess® I and HIPaccess® 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
- 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

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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.

For GMI HMO Members

The referred PT/OT provider must, within three business days of the initial evaluation, 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.

If additional visits are needed to resolve the condition within the benefit time frame, physical therapy and occupational therapy providers must complete a **PT/OT Treatment Form** through www.palladianhealth.com or via fax to **1-716-712-2817**.

In the case of serious illness or injuries where reasonable medical necessity would indicate treatment continuing beyond the members yearly benefit limit, the therapist may request a benefit extension by contacting GHI HMO directly at **1-877-244-4466**.

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

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For HIP Members

PT/OT practitioners, whether in private practice or in an outpatient facility, must obtain prior approval from Palladian for the member's second treatment, and each continued treatment thereafter, by submitting the necessary forms through www.palladianhealth.com or via fax to **1-716-809-8324**.

- **Individual and/or Group Outpatient Practitioners** are required to complete the necessary forms prior to the first post-evaluation visit. Forms can be completed online at www.palladianhealth.com or downloaded and faxed to Palladian at **1-716-809-8324**.
- **Outpatient Facility Services** are required, after the initial evaluation, to request prior approval directly from Palladian rather than confirming that a prior approval has been issued and posted to www.emblemhealth.com. For ongoing care, complete and submit Palladian's required forms at www.palladianhealth.com.

Submitting Requests for Medical Review

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

- **The PT/OT Treatment Form** (to be completed by the participating therapist)
- **The PT/OT Intake Form** (to be completed by the patient)
- **The PT/OT Outcomes Form** (to be completed by the patient) or the **PT/OT Pediatric Outcomes Form** (to be completed by the parent or guardian of patients under the age of 18)

These forms are on www.emblemhealth.com and www.palladianhealth.com. The practitioner is responsible for submitting all forms to Palladian for review.

You may submit the completed forms electronically from www.palladianhealth.com or you 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.
 - **PT/OT Treatment Form** - completed by the therapist
 - **PT/OT Intake Form** - completed by the patient
 - **PT/OT 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."
 - **PT/OT Treatment Form** - completed by the therapist
 - **PT/OT Outcomes Form** - completed by the patient
- All requests for additional care may be processed or submitted at www.palladianhealth.com.

OUTPATIENT HOSPITAL RETROSPECTIVE UTILIZATION REVIEWS FOR HIP CLAIMS

Retrospective Utilization Reviews (RURs) are clinical in nature and may be requested when HIP

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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

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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.

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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 For electronic claims submission, Palladian's Payor ID is 37268.	CMS-1500
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

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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

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Please fax completed form to:
716-809-8335

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



Section A. Provider information		Appeal type <input type="radio"/> Standard <input type="radio"/> Expedited	
Last name	<input type="text"/>	Tax ID	<input type="text"/>
Section B. Patient information		Plan	<input type="text"/>
Last name	<input type="text"/>	Member ID	<input type="text"/>
Section C. Denial information		M M D D Y Y Y Y	
Authorization number	<input type="text"/>	Date of denial	<input type="text"/> - <input type="text"/> - <input type="text"/>
Section D. Basis for appeal. (Check all that apply. Please provide any additional documentation that is needed.)			
<p>1. Poor compliance related to...</p> <ul style="list-style-type: none"> <input type="radio"/> patient unable to attend scheduled visits (e.g. too busy, unable to take time off work, primary caregiver at home) <input type="radio"/> patient not performing recommended home care or home exercises (e.g. improvement only noted after visit to provider) <input type="radio"/> difficulties communicating with patient (e.g. language, cultural, or other barriers) <p>2. Recent re-injury affecting primary region of complaint...</p> <ul style="list-style-type: none"> <input type="radio"/> continued or repeated exposure to injuring activity (e.g. unable to modify activities, unable to change nature of work) <input type="radio"/> acute re-injury occurred on: (MM-DD-YYYY) <input type="text"/> - <input type="text"/> - <input type="text"/> <p>3. Potential complicating factors...</p> <ul style="list-style-type: none"> <input type="radio"/> patient involved in litigation related to region of complaint (e.g. worker's compensation, no-fault, personal injury) <input type="radio"/> patient receiving benefits related to ongoing incapacity (e.g. worker's compensation, SSDI) <p>4. Outcomes Form does not accurately reflect patient's health status because it...</p> <ul style="list-style-type: none"> <input type="radio"/> underestimates the severity of patient's physical or mental health (e.g. questions 1-12 on Outcomes Form) <input type="radio"/> underestimates the severity of patient's symptoms (e.g. questions 13-16 on Outcomes Form) <input type="radio"/> observed clinically meaningful improvements not reflected on the Outcomes Form <p>5. Diagnosis recently changed for primary region of complaint based on...</p> <ul style="list-style-type: none"> <input type="radio"/> experience treating this patient (e.g. initial working diagnosis did not accurately reflect severity of condition) <input type="radio"/> new diagnostic testing results obtained on: (MM-DD-YYYY) <input type="text"/> - <input type="text"/> - <input type="text"/> <p>6. Patient not receiving required medical or surgical intervention...</p> <ul style="list-style-type: none"> <input type="radio"/> patient unable or unwilling to undergo required medical or surgical procedure (e.g. medication, joint replacement) <input type="radio"/> surgical or medical procedure scheduled on: (MM-DD-YYYY) <input type="text"/> - <input type="text"/> - <input type="text"/> <p>procedure: <input type="text"/></p> <p>7. Patient has co-morbidities that interfere or delay expected improvements, including...</p> <ul style="list-style-type: none"> <input type="radio"/> fear avoidance behavior that precludes performing supervised exercise therapy (e.g. unable to try exercises) <input type="radio"/> severe anxiety or depression that interferes with supervised exercise therapy (e.g. unwilling to try exercises) <input type="radio"/> poor healing response following injury or surgical procedure (e.g. excessive scar tissue formation) <input type="radio"/> other regions of complaint in addition to primary region of complaint (please indicate below) <p><input type="text"/></p> <p>8. Remaining symptoms or functional limitations expected to resolve completely with additional visits...</p> <p><input type="radio"/> Not applicable <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> other</p> <p>Comments: _____ _____</p>			

Provider signature

Date of appeal



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**PT/OT Patient Intake Form
(version 1.5)**

www.palladianhealth.com/members



Last name	First name																											
<p>PLEASE COMPLETELY FILL IN THE <u>ONE</u> CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)</p>																												
<p>1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="radio"/> Neck</td> <td><input type="radio"/> Shoulder</td> <td><input type="radio"/> Hip</td> <td><input type="radio"/> Stroke rehabilitation</td> <td rowspan="4" style="vertical-align: top;">Other (also indicate region)</td> </tr> <tr> <td><input type="radio"/> Upper/ mid-back</td> <td><input type="radio"/> Elbow</td> <td><input type="radio"/> Knee</td> <td><input type="radio"/> Spinal cord rehabilitation</td> </tr> <tr> <td><input type="radio"/> Lower back</td> <td><input type="radio"/> Wrist</td> <td><input type="radio"/> Ankle</td> <td><input type="radio"/> Neurologic rehabilitation</td> </tr> <tr> <td><input type="radio"/> Hand</td> <td><input type="radio"/> Foot</td> <td><input type="radio"/> Balance/coordination</td> <td><input type="radio"/> Post-surgical</td> </tr> <tr> <td colspan="4"></td> <td><input type="radio"/> Fracture</td> </tr> <tr> <td colspan="4"></td> <td><input type="radio"/> Other</td> </tr> </table>		<input type="radio"/> Neck	<input type="radio"/> Shoulder	<input type="radio"/> Hip	<input type="radio"/> Stroke rehabilitation	Other (also indicate region)	<input type="radio"/> Upper/ mid-back	<input type="radio"/> Elbow	<input type="radio"/> Knee	<input type="radio"/> Spinal cord rehabilitation	<input type="radio"/> Lower back	<input type="radio"/> Wrist	<input type="radio"/> Ankle	<input type="radio"/> Neurologic rehabilitation	<input type="radio"/> Hand	<input type="radio"/> Foot	<input type="radio"/> Balance/coordination	<input type="radio"/> Post-surgical					<input type="radio"/> Fracture					<input type="radio"/> Other
<input type="radio"/> Neck	<input type="radio"/> Shoulder	<input type="radio"/> Hip	<input type="radio"/> Stroke rehabilitation	Other (also indicate region)																								
<input type="radio"/> Upper/ mid-back	<input type="radio"/> Elbow	<input type="radio"/> Knee	<input type="radio"/> Spinal cord rehabilitation																									
<input type="radio"/> Lower back	<input type="radio"/> Wrist	<input type="radio"/> Ankle	<input type="radio"/> Neurologic rehabilitation																									
<input type="radio"/> Hand	<input type="radio"/> Foot	<input type="radio"/> Balance/coordination	<input type="radio"/> Post-surgical																									
				<input type="radio"/> Fracture																								
				<input type="radio"/> Other																								
<p>2. When did this problem first begin?</p> <p><input type="radio"/> Less than 1 month ago <input type="radio"/> 1-3 months ago <input type="radio"/> 4-6 months ago <input type="radio"/> 7-12 months ago <input type="radio"/> More than 1 year ago</p>																												
Has this problem...																												
No Yes																												
3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?																												
<input type="radio"/> <input type="radio"/>																												
4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?																												
<input type="radio"/> <input type="radio"/>																												
5. ... recently been evaluated by a medical doctor?																												
<input type="radio"/> <input type="radio"/>																												
Since this problem began, have you noticed...																												
No Yes																												
6. ... so much weakness in both your arms that you are unable to lift them?																												
<input type="radio"/> <input type="radio"/>																												
7. ... so much weakness in both your legs that you are unable to walk without help?																												
<input type="radio"/> <input type="radio"/>																												
8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?																												
<input type="radio"/> <input type="radio"/>																												
9. ... pain in your chest, shortness of breath, or coughing up blood?																												
<input type="radio"/> <input type="radio"/>																												
10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?																												
<input type="radio"/> <input type="radio"/>																												
Have you recently...																												
No Yes																												
11. ... had blurred vision, double vision, dizziness, or fainting?																												
<input type="radio"/> <input type="radio"/>																												
12. ... had any type of infection, fever, or chills?																												
<input type="radio"/> <input type="radio"/>																												
13. ... had any type of surgery, surgical procedure, or medical procedure?																												
<input type="radio"/> <input type="radio"/>																												
14. ... lost a lot of weight without really trying to (i.e without being on a diet)?																												
<input type="radio"/> <input type="radio"/>																												
15. ... had any type of accident, fall, or trauma?																												
<input type="radio"/> <input type="radio"/>																												
Have you ever...																												
No Yes																												
16. ... been diagnosed with cancer?																												
<input type="radio"/> <input type="radio"/>																												
17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?																												
<input type="radio"/> <input type="radio"/>																												
18. ... been diagnosed with a weakened immune system?																												
<input type="radio"/> <input type="radio"/>																												
19. ... used any injected drugs (i.e. non-prescription drugs)?																												
<input type="radio"/> <input type="radio"/>																												
20. ... used steroids such as prednisone for more than 4 weeks?																												
<input type="radio"/> <input type="radio"/>																												
Is this problem something that ...																												
No Yes																												
21. ... you've had before?																												
<input type="radio"/> <input type="radio"/>																												
22. ... generally gets worse (i.e more severe or frequent) with movement, activity, or exercise?																												
<input type="radio"/> <input type="radio"/>																												
23. ... generally gets better (i.e. less severe or frequent) with rest?																												
<input type="radio"/> <input type="radio"/>																												
24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?																												
<input type="radio"/> <input type="radio"/>																												
25. ... is also being treated by a health professional other than a physical or occupational therapist?																												
<input type="radio"/> <input type="radio"/>																												

17131



V:PalladianPTOTintake(1.5)20100113



PHYSICAL AND OCCUPATIONAL THERAPY PROGRAM



PT/OT Pediatric Outcomes Form
(version 1.5)

www.palladianhealth.com/members



Last Name		First name	
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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 <input type="radio"/>	Very good <input type="radio"/>	Good <input type="radio"/>	Fair <input type="radio"/>	Poor <input type="radio"/>									
2. During the past week, has your child been limited in any of the following activities due to HEALTH problems? Doing things that take some energy such as riding a bike or skating?													
Yes, limited a lot <input type="radio"/>	Yes, limited some <input type="radio"/>	Yes, limited a little <input type="radio"/>	No, not limited <input type="radio"/>										
3. Bending, lifting, or stooping?													
Yes, limited a lot <input type="radio"/>	Yes, limited some <input type="radio"/>	Yes, limited a little <input type="radio"/>	No, not limited <input type="radio"/>										
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 <input type="radio"/>	Yes, limited some <input type="radio"/>	Yes, limited a little <input type="radio"/>	No, not limited <input type="radio"/>										
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 <input type="radio"/>	Yes, limited some <input type="radio"/>	Yes, limited a little <input type="radio"/>	No, not limited <input type="radio"/>										
6. During the past week, how much bodily pain or discomfort has your child had?													
None <input type="radio"/>	Very mild <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>	Very Severe <input type="radio"/>								
7. During the past week, how satisfied do you think your child has felt about his/her friendships?													
Very satisfied <input type="radio"/>	Somewhat satisfied <input type="radio"/>	Neither satisfied nor dissatisfied <input type="radio"/>	Somewhat dissatisfied <input type="radio"/>	Very dissatisfied <input type="radio"/>									
8. During the past week, how satisfied do you think your child has felt about his/her life overall?													
Very satisfied <input type="radio"/>	Somewhat satisfied <input type="radio"/>	Neither satisfied nor dissatisfied <input type="radio"/>	Somewhat dissatisfied <input type="radio"/>	Very dissatisfied <input type="radio"/>									
9. During the past week, how much of the time do you think your child acted bothered or upset?													
All of the time <input type="radio"/>	Most of the time <input type="radio"/>	Some of the time <input type="radio"/>	A little of the time <input type="radio"/>	None of the time <input type="radio"/>									
10. Compared to other children your child's age, in general would you say his/her behavior is:													
Excellent <input type="radio"/>	Very good <input type="radio"/>	Good <input type="radio"/>	Fair <input type="radio"/>	Poor <input type="radio"/>									
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		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
12. On average		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
13. At its best		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14. At its worst		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	


57344



V:PalladianPTOTpediatric(1.5)20100203




PHYSICAL AND OCCUPATIONAL THERAPY PROGRAM



18650

ICD-10 PT/OT Treatment Form
(version 2.1)
www.palladianhealth.com/providers



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

Specialty: PT OT NPI

Section A. Provider information										Service Street Address									
First name																			
Last name																			
Facility name																			

Section B. Patient information										Date of Birth									
First name										M M		D D		Y Y Y Y					
Last name										-		-		-					
Health plan										-		-		-					
Member ID										-		-		-					

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

Spine <input type="radio"/> Cervical <input type="radio"/> C/S+radiculopathy <input type="radio"/> Thoracic <input type="radio"/> Lumbosacral <input type="radio"/> L/S+radiculopathy	Upper extremity Shoulder <input type="radio"/> L <input type="radio"/> R Elbow <input type="radio"/> L <input type="radio"/> R Wrist <input type="radio"/> L <input type="radio"/> R Hand <input type="radio"/> L <input type="radio"/> R	Lower extremity Hip <input type="radio"/> L <input type="radio"/> R Knee <input type="radio"/> L <input type="radio"/> R Ankle <input type="radio"/> L <input type="radio"/> R Foot <input type="radio"/> L <input type="radio"/> R	Other (also indicate region) <input type="radio"/> Post-surgical <input type="radio"/> Fracture <input type="radio"/> Other	Rehabilitation <input type="radio"/> Stroke <input type="radio"/> Spinal cord <input type="radio"/> Neurological <input type="radio"/> Balance/coordination
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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
<input type="radio"/> Very mild <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Very severe	<input type="radio"/> Very good <input type="radio"/> Good <input type="radio"/> Moderate <input type="radio"/> Poor <input type="radio"/> Very poor	<input type="radio"/> Very good <input type="radio"/> Good <input type="radio"/> Moderate <input type="radio"/> Poor <input type="radio"/> Very poor	<input type="radio"/> Very good <input type="radio"/> Good <input type="radio"/> Moderate <input type="radio"/> Poor <input type="radio"/> Very poor

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

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

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.

PHYSICAL AND OCCUPATIONAL THERAPY PROGRAM



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: <input type="checkbox"/> M <input type="checkbox"/> F	Policy holder certificate no:	
Insured last name:		Insured first name:	Telephone no:
Name of provider rendering service:			Tax ID no:
Participating provider? <input type="checkbox"/> Y <input type="checkbox"/> 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): <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MVA-related <input type="checkbox"/> WC-Related <input type="checkbox"/> 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: <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N		Has patient been instructed in a home exercise program? <input type="checkbox"/> Y <input type="checkbox"/> N	
Number of visits to reach MMI: _____		Prognosis:	
From date: ___/___/___ To date: ___/___/___			
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.

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

EMB_PR_FRM_15037_BenExtTreatPlan 8/13



PHYSICAL AND OCCUPATIONAL THERAPY PROGRAM



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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PHYSICAL AND OCCUPATIONAL THERAPY PROGRAM

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Date of birth: ___/___/___	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Policy holder certificate no:	
Insured last name:		Insured first name:	Telephone no:
Name of provider rendering service:			Tax ID no:
Participating provider? <input type="checkbox"/> Y <input type="checkbox"/> 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): <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MVA-related <input type="checkbox"/> WC-Related <input type="checkbox"/> 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: <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N		Has patient been instructed in a home exercise program? <input type="checkbox"/> Y <input type="checkbox"/> N	
Number of visits to reach MMI: _____		Prognosis:	
From date: ___/___/___ To date: ___/___/___			
Start of care (this year):		Visits used to date (this year):	

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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?			
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