Palladian
Muscular Skeletal Health

insight

The Palladian Health ® Provider Newsletter Spring 2017

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New EmblemHealth Membership

Palladian is pleased to welcome a new group of EmblemHealth members to our physical therapy network program.

EmblemHealth members who previously received physical therapy services at AdvantageCare Physicians (ACPNY) locations in the metropolitan NYC area, including Long Island, will receive in-network services from the Palladian Health PT provider network, effective April 1, 2017.

Both Palladian and Emblem are committed to assisting members during the transition to select a Palladian Health network PT provider. Emblem members will be directed toward our online database of network providers. Please ensure that your information in that database is accurate and current, including practice addresses and contact information. The provider search function on our Web site can be found at https://portal.palladianhealth.com/search/.

All prior authorizations and claims for these members will be managed by Palladian Health. Requests for prior authorization can be submitted through the Palladian Web site or by fax, using the same process that's in place today. Claims should be sent to Palladian Health LLC, P.O. Box 366, Lancaster, NY 14086 for processing. If you have any questions regarding services, please contact customer service at 1-877-774-7693.

Provider Directory

In an effort to keep our provider directories up to date we are reaching out to our network providers quarterly as a reminder to ensure that your information in our provider directory is accurate. Quarterly reminders to providers are a CMS requirement (CMS memorandum dated Nov. 13, 2015). Please notify us of any changes needed at:

Palladian Phone #	Palladian Fax #	Chiro Alliance Phone #	Chiro Alliance Fax #
1-888-266-9041 x 2744	1-716-712-2791	1-727-319-6199	1-727-395-0071

CMS Issues Updated Guidance on Adjudication of Coverage Decisions

On October 18, 2016, CMS issued a clarification related to Medicare Advantage organization requesting information from providers when adjudicating coverage decisions, also known as organization determinations. CMS developed the guidance following repeated audits that identified necessary information to make informed coverage decisions was not always available. This lack of information could result in unnecessary coverage denials, increased appeals, and potential access delays for beneficiaries.

As a result, CMS has developed 'reasonable outreach guidance' that applies when the plan and/or the UM delegate does not have all the information that it needs, including medical records and other pertinent documentation, to make a coverage decision. Medicare Advantage health plans and Palladian, as a Medicare Advantage health plan delegate, are required to make reasonable and diligent efforts to obtain all necessary information from the enrollee's provider in order to make coverage decisions as expeditiously as the enrollee's health condition requires.

Palladian must conduct a full and meaningful review of an organization determination request. CMS expects that we gather all of the information needed to make substantive and accurate decisions as early in the coverage process as possible.

CMS has clarified that the process must include the following:
If the coverage request is made by a contracted provider on behalf of the enrollee, and necessary information is not included within the request:

- Palladian must clearly identify and request the records and information needed from the provider.
- If the provider does not respond to the request, Palladian must conduct outreach to the contracted provider.
- CMS defines outreach for missing information as:
  - -A minimum of three attempts to request the information
  - -Methods to request can include:
    - >Telephone
    - >Fax
    - >Email
    - >Standard or overnight mail with certified return receipt
- The first request for information should be made within two calendar days of receipt of the coverage request.
- CMS expects that subsequent requests to be timed to increase likelihood of making contact and receipt of the information.
- CMS expects that, contracted providers will submit the requested information in a reliable and timely manner, in compliance with their provider agreements with Health Plans and/or Health Plan delegates who conduct utilization management.

CMS Guidance/Adjudication of Coverage Decisions Cont...

What can you do to avoid requests for additional information?

1. When submitting your requests on the Palladian Web portal or when completing paper forms, be sure to complete each entry on the treatment form, the outcomes form, and if applicable the intake form.
2. Ensure that all member and provider demographic information is accurate, such as the member name, identification number, provider name, NPI, office location where the service will be provided.
3. Enter specific diagnosis and procedure codes and/or descriptions, as appropriate to the enrollee's condition and needed services.
4. Enter applicable dates accurately. These may include: surgery date, authorization start date, onset date, and/or last visit date.
5. If Palladian asks you to provide more information, submit the requested documents within three to four days. This response time will reduce the risk that Clinical Services staff will reach out to you to follow-up on our request.

Palladian must render and mail decisions for standard Medicare organization requests within fourteen calendar days from receipt of the request. Palladian must render decisions for expedited Medicare organization requests within 72 hours from receipt.

A copy of the CMS memo can be obtained at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/HPMS-Guidance-on-Outreach-for-Information-to-Support-Coverage-Decisions-2016Oct18.pdf .

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Education for Spine Pain

Palladian Health, as part of its quality improvement program, has continued an analysis of the education given by providers, both PTs and DCs to patients who present with spine pain, including neck pain, mid back pain and low back pain. This analysis was performed on both physical therapy and chiropractic providers for submissions received from 01/01/2016 through 12/31/2016.

Evidence based guidelines (EBG) strongly support the use of patient education concerning the diagnosis, prognosis and active home or self-care. Patients who become actively engaged in the course of care have been shown to have improved clinical outcomes. The reinforcement of the educational process should be repeated throughout the course of care.

Patient education includes, but is not limited to, discussion of the diagnosis, the anticipated prognosis, instructions for remaining active, self-care with home modalities such as ice or heat and recommendations or instruction for exercises. Exercises may be specific, such as performing piriformis muscle stretches or general exercises such as walking for a period of time.

For the purposes of this quality improvement project data was collected from the PT/DC Treatment forms. After excluding those patients under the age of 18, all submissions for each patient by provider were tabulated.

The results indicated that DCs were completing patient education in 48% of the cases, whereas PTs were doing so in 64% of the cases