Palladian
Muscular Skeletal Health

insight

THE PALLADIAN HEALTH PROVIDER NEWSLETTER SUMMER/FALL 2017

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Welcome!

Welcome to our newest providers who have recently joined our network:

Yasser Abdalla, PT	Minnie Escobia, PT	Rachel Lerner, OT	Kimberly Romaine, DC
Amr Abdelaziz, PT	Raymond Evans, DC	Ian Lim, PT	Yuliya Royberman, OT
Kristin Adduci, LMHC	Jessica Farrell, DC	Donald Lorentz, DC	Glenn Rugen, DC
Keila Aguglia, DC	Vladimir Fedosseev, PT	Gary Majkowski, DC	Robert Rugen, DC
Gerardo Alfaro, DC	Ian Ferrar, DC	Emmanuel Maranan, PT	Susan Sanders, DC
Jeffrey Altamirano, PT	Brian Ferry, DC	Gregory Marcolin, PT	Jamie Santoro, DC
Lisa Balderman, LCSW	Amged Gad, PT	Anish Mathew, PT / OT	Shruti Shah, PT
Richard Baluran, PT	Enrique Garcia, PT	Kimberley Miranda, PT	Dmitry Shevchenko, OT
Kenneth Bass, DC	Jennifer Gilmore, DC	Seong Hoon Moon, PT /OT	John Sobrevega, PT
Kayla Beardsley, DC	Brandon Goulding, PT	Ksio Murdakhayeva, PT	Elya Spolar, PT
Anupam Bhuniya, PT	Lauri Graham, DC	Pamela Myers, LCSW-R	Russ Tannenbaum, DC
Nicole Brock, PT	Elaine Herrick, DC	Stephen Noel, DC	Travis Tennie, PT
John Bucci, DC	Jeffrey Hoffman, DC	Sherwin Paller, PT	Manju Thomas, PT
Michael Chanatry, DC	Ronald Huneberg, DC	Kristine Philliponi, PT	Amy Wang, LAC
Alessandra Colon, DC	Denny Julewicz, DC	Robert Power, DC	Akriti Yadav, PT
Bryan Davidson, PT	Kishore Kanduri, PT	David Preston, DC	
Anthony Debe, DC	Chang Kim, DC	Manuel Prisciandaro, DC	

Affirmative Statement about Incentives

In compliance with NCQA UM 4, Element F, Palladian Health affirms the following:

- UM decision making is based only on appropriateness of care and service and existence of coverage
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization

Medicare Advantage Coverage Decisions– CMS Guidance

CMS recently provided clarifying guidance related to requesting information (e.g. clinical documentation) from providers when adjudicating coverage decisions. According to federal regulations, Palladian Health must have processes in place for making coverage decisions, which include asking for and obtaining necessary clinical documentation from the treating provider.

CMS expects that, based upon the contractual relationship between Palladian Health and contracted providers, Palladian will be able to request and obtain requested information from contracted providers in a reliable and timely manner. As part of required procedures, CMS expects the following:

- Palladian will make initial attempts to obtain necessary information within two calendar days of receipt of the request.
- We will make attempts to reach you during business hours in your time zone, when possible.
- Palladian will make up to three outreach attempts to obtain the information. Attempts will be made by telephone, fax, or by mail, to increase the likelihood of making contact with you and receive the information.
- Documentation of requests for information will be kept in the file, and will include a specific description of the required information, the name, phone number, fax number, and/or mailing address, as applicable for the point of contact, and the date/time of each request along with who was contacted, what was discussed, and what information was obtained.

If Palladian does not obtain the requested information, we will make a decision, based upon the available information, in the timeframe required by CMS.

This policy is designed to satisfy requirements to issue coverage decisions as expeditiously as the enrollee's health condition requires.

Timely Filing

All chiropractic submissions for continued care should be submitted in a timely manner. The completed forms need to be submitted within five business days of the Requested Start Date to be considered timely.

The Last Date Seen should only be reported as the same date as the Requested Start Date in the case of a patient new to your office. In all other instances enter the most recent prior date of service. This will help to establish a break in care or withdrawal from care and establish a new episode of care. Presently, physical therapists do not have a requirement for timely filing.

Quality Management and Improvement Summary

This summary provides a synopsis of our Quality Management and Improvement Program (QMIP) established to improve all services and outcomes for sponsor health plan members. The entire QMIP is available on the provider portal of the Palladian Web site.

OVERVIEW

Palladian is committed to continuously and systematically monitoring, evaluating and improving clinical and administrative services for all clients and consumers, as well as health care services for members. The QMIP establishes the protocol to evaluate and monitor services received by sponsor health plan members.

GOALS

QMIP objectives include:

- To assure that members receive medically necessary care within an environment that demonstrates clinical quality consistent with prevailing professionally recognized standards of clinical practice, maximizes safe clinical practices and enhances services throughout the organization
- To ensure the availability and accessibility to continuity of care for each member consistent with the members' clinical condition, including procedures for identification, evaluation, resolution and follow up of potential and actual problems in their administration and deliverance of health care services
- To ensure that members have access to safe practice sites and safe clinical services
- To ensure the improvement of patient safety through fostering a supportive environment to help practitioners and providers improve the safety of their practices
- To ensure that network practitioners/providers understand and utilize safe clinical practices
- To ensure that members have access to practitioners/providers who are qualified and proficient within their area of practice
- To focus attention on quality initiatives that will improve member safety
- To ensure that service quality, to clients and member/consumers alike, is compliant with regulations and standards
- To ensure that clinical and administrative services are monitored and necessary interventions implemented

CLINICAL & ADMINISTRATIVE SCOPE

Program scope includes both clinical and administrative topics. Special emphasis is placed upon topics that monitor frequently performed or highly specialized activities:

- Development and monitoring of compliance with clinical protocols and practice guidelines
- Clinical measurement activities/projects with emphasis on projects that impact member safety
- Outcome analysis
- Monitoring and improving network practitioner medical record documentation and record keeping practices
- Improving continuity and coordination of care
- Protecting patient safety
- Clinical quality indicator monitoring/peer review with emphasis on identification of events that may put members at risk
- Risk management
- Utilization management (including but not limited to over-and underutilization)

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- Network practitioner performance reporting
- Accurate and timely processing of claims
- Appropriate accessibility and availability of service
- Call center operations
- Confidentiality
- Member and practitioner satisfaction
- Culturally and linguistically appropriate services
- Network adequacy including the effectiveness of the network in meeting the needs and preferences of the membership
- Special needs members
- Timely, accurate and appropriate handling of service utilization requests (utilization review submissions).

AUTHORITY & RESPONSIBILITY

The board of managers supports the QMIP through its endorsement of the program and allocation of resources. The governing body retains final accountability for the quality program and receives written reports delineating performance measures and results, analysis of results with identification of opportunities for improvement, action plans, and improvements. The executive QMIP committee/compliance committee oversees all committee activities and reports to the board of directors. All committee activities, including but not limited to, the executive QMIP committee, the quality management and improvement committee, credentialing committee, and the Clinical Policy Advisory Board sustain reporting lines that lead to the board of directors.

Corporate committees such as the quality management and improvement committee and the credentialing committee include network practitioners as committee members in order for Palladian to benefit from the treating practitioner's viewpoint and expertise. All staff throughout the organization participate in the QMIP. Palladian Health's chief medical officer has direct responsibility for the QMIP. Vice presidents of clinical services are integral to the implementation of the clinical aspects of the QMIP.

COMMUNICATION OF QUALITY MANAGEMENT & IMPROVEMENT INFORMATION

In accordance with federal and state regulations and accrediting agency guidelines, Palladian annually makes various quality management and improvement documents available for review. Information is reported to regulatory bodies, accrediting agencies and client health plans as required by the jurisdiction's laws and/or standards. Palladian makes information about the quality management and improvement program, including a description of the quality management and improvement program and a report on the organization's progress in meeting its goals, available to its members and practitioners. Practitioners/providers also receive reports relative to member satisfaction.

STATEMENT OF CONFIDENTIALITY

In accordance with federal and state regulations, quality management and improvement activities are conducted in a manner, which ensures the confidentiality of all information. Palladian acquires, uses, and stores protected information in a confidential manner. Data is handled responsibly with regard to privacy of the involved member or practitioner/provider. Regulatory bodies shall have access to minutes or records in accordance with jurisdiction governing the client health plan.

Member Rights and Responsibilities

Palladian Health is committed to treating members in a manner that respects their rights and its expectations of member's responsibilities. Palladian distributes its member rights and responsibilities statement to new practitioners when they join the network and existing practitioners annually. Palladian notifies members of the availability of its Member Rights and Responsibilities Statement when delegated by sponsors of programs.

Members have a right to:

- Receive information about the organization, its services, its practitioners and providers, its policies and procedures, and members' rights and responsibilities
- Be treated with respect and with recognition of their dignity and right to privacy
- Participate with practitioners and providers in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their conditions,
- regardless of cost or benefit coverage
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the organization's Member Rights and Responsibility policy
- Information about available services, including how to obtain urgent, emergency and after hours care
- Confidentiality of their medical records
- Know the system for resolving complaints, including their right to appeal to the appropriate Department of Health or Department of Insurance
- A choice of specialists among participating practitioners and providers, subject to their availability to accept new patients
- Obtain assistance and referral to participating practitioners and providers with experience in the treatment of members with chronic disabilities
- Prompt notification of termination or other changes to the practitioner/provider network
- Payment of appropriate benefits, when medically necessary

Patients have a right to expect the following from their practitioners and providers:

- Participation in decisions concerning their health care
- The right to refuse treatment to the extent permitted by law, and be informed of the medical consequences of that action
- To obtain complete and current information concerning a diagnosis, treatment or prognosis in terms they can reasonably understand. Note: When it is not advisable to give such information to the member, the information shall be made available to an appropriate person on the member's behalf
- To receive information from the practitioner or provider necessary to give informed consent prior to the start of any procedure
- To know the name and qualifications of all caregivers. This information can be obtained from the practitioner or provider or the administrator of any health care facility
- If a patient feels that their practitioner or provider has not given the kind of service that they have the right to expect, the patient has the right to follow the complaint procedure
- To be free from balance billing by participating practitioners and providers for medically necessary services that were authorized or covered, except for co-payments, coinsurance and deductibles

Members have a responsibility to…

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care
- Follow plans and instruction for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
- Establish themselves as a member with the practitioner or provider they have selected
- Provide honest and accurate information concerning their health history and status
- Ensure that their primary care physician coordinates any health care that the member receives in order to receive the highest level of benefits
- Carefully follow their plan's policies and procedures as described in their contract and rider(s)
- Carry their insurance identification card and present it when seeking health care services
- Advise their insurance carrier of any changes, which affect their family such as birth, change of address or marriage
- Submit all bills from non-participating practitioners and providers in a timely manner, within plan parameters
- Notify their insurance carrier when anyone included in their coverage becomes eligible for Medicare or any other group health care insurance
- Keep their insurance carrier informed of their concerns about medical care received
- Pay appropriate co-payments, coinsurance and deductibles to participating practitioners and providers when services are received
- Pay charges incurred for non-covered services
- Formulate and have advance directives implemented

Palladian Health notifies participating practitioners annually that the rights and responsibilities statement is available on the Palladian Health Web site. Practitioner notification may occur by fax, email, or direct mail. Member communications regarding rights and responsibilities is not delegated to Palladian. If member distribution is delegated, Palladian notifies member through direct mail.

Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients.

You may request a copy of the full text of this law from your health care provider or health care facility. Florida statute requires that the Florida Patient's Bill of Rights and responsibilities and the Florida Consumer Assistance Notice be prominently displayed in their office waiting room and/or common area.

A summary of your rights and responsibilities follows.

A patient has the right to...

- Be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy
- A prompt and reasonable response to questions and requests
- Know who is providing medical services and who is responsible for his or her care
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English
- Know what rules and regulations apply to his or her conduct
- Be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care
- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research
- Express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency

Patient responsibilities…

- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her

- A patient is responsible for following the treatment plan recommended by the health care provider
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct

Florida Consumer Assistance Notice
Statewide Consumer Call Center
1-888-419-3456

Division of Consumer Services
200 E. Gaines Street
Tallahassee, FL 32399-0322

Department of Financial Services (formally Department of Insurance)
1-800-342-2762
2727 Mahan Drive, Mail Stop 27
Tallahassee, FL 32308

Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 27
Tallahassee, FL 32308

Change of address or phone?

In an effort to keep our provider directories up to date with the most current information, as required by CMS, we are reaching out to our network providers quarterly as a reminder to ensure that your information in the provider directory is accurate. **Please notify Palladian Health of any changes 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