Provider Manual

Chapter 24: Chiropractic Program

EmblemHealth partners with Palladian Musculoskeletal Health (Palladian), a specialty network and utilization management organization, to manage chiropractic services for our Commercial (including Child Health Plus and Essential Plan) and Medicare members according to their benefit plans.

Hospital Outpatient Facility

Palladian conducts preauthorization review for chiropractic services delivered at a hospital outpatient facility. However, claims processing and appeals for denial determinations of these services are handled directly by EmblemHealth.

Professional Services

Palladian also conducts preauthorization review for non-hospital settings, processing professional claims and appeals for denial determinations made on professional claims (excluding members with Medicare plans).

Preauthorizations do not guarantee claims payment. Services must be covered by the member's health plan and the member must be eligible at the time services are rendered. Claims submitted may be subject to benefit denial. Prior to rendering services, all providers must verify member eligibility and benefits at emblemhealth.com/providers.

Credentialing and Recredentialing

Palladian is responsible for the credentialing and recredentialing of chiropractors who are part of their network. For information on credentialing with Palladian, contact Palladian's Customer Service at **877-774-7693**. All others, see the Credentialing chapter of the Provider Manual and our Join Our Network page.

Exempt Members

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

- Medicaid members do not have chiropractic benefits.
- Members whose ID card indicates a primary care physician from one of the following entities:

  - HealthCare Partners (HCP) Cohort I
  - Montefiore (CMO)
- EmblemHealth Insurance Company (formerly HIP Insurance Company of New York (HIPIC)) EPO/PPO plans
- Bridge Program ASO members

Practitioners must contact the applicable organization for preauthorization. Check the member's ID card or eligibility information on emblemhealth.com/providers to determine the Managing Entity. See the Utilization and Care Management chapter of this Provider Manual for applicable rules and preauthorization processes. You may also use the Preauthorization Lookup tool on the provider portal to determine if a preauthorization is required and who is responsible for conducting the review.

TIP: Check member ID cards at every visit, regardless of service or reason for the visit.

Preauthorizations and Referrals

Palladian conducts medical necessity review for chiropractic services to assess the patient's current medical condition, pain, and progression of treatment. The medical necessity review process is user-friendly and designed to gather concise information from you and your patient to determine the appropriate course of care.

When Preauthorization is Required

Members with chiropractic benefits are generally allowed unlimited visits to a network chiropractor, based on medical necessity, preauthorization, and referral requirements, which vary according to the member's benefit.

The initial visit to a chiropractor does not require preauthorization. Chiropractors must obtain preauthorization from Palladian for the member's second treatment and each treatment thereafter.

EmblemHealth Plan, Inc. (formerly GHI) Underwritten Benefit Plans

Members may access chiropractic care without a referral or preauthorization for the first eight visits, depending on the member's benefit. Chiropractors must obtain preauthorization from Palladian for the ninth visit and each treatment thereafter.

How to Request Preauthorization

Chiropractors and their patients must complete required forms as indicated below. Chiropractors are responsible for submitting all forms to Palladian for review.

- **Chiropractic Treatment Form** - completed by the participating therapist
- **Chiropractic Intake Form** - completed by the patient
- **Chiropractic Outcomes Form** - completed by the patient; or the

- **Pediatric Outcomes Form** - completed by the parent or guardian of patients under the age of 18

Below 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 (3) forms need to be submitted within five (5) business days of the initial evaluation.
  - **Chiropractic Treatment Form -** completed by the participating therapist
  - **Chiropractic Intake Form -** completed by the patient
  - **Chiropractic Outcomes Form -** completed by the patient
- For any additional follow-up care after the initial authorization, the following two (2) forms need to be submitted within five (5) business days of the "Requested Start Date."
  - **Chiropractic Treatment Form -** completed by the participating therapist
  - **Chiropractic Outcomes Form -** completed by the patient

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

Once the forms are complete, chiropractors may submit preauthorization requests in one of two ways:

1. **Online:** Visit evicore.com/palladian.
2. **By fax:** Use **716-712-2802** for HIP members or **716-712-2817** for EmblemHealth Plan, Inc. (formerly GHI members).

Claims Submissions

Professional providers seeing members under the Chiropractic Program should submit claims directly to Palladian:

EDI or Payor ID: 37268

Clearing House: Vendor

Paper Submission Address:

Palladian Health
P.O. Box 366
Lancaster, NY 14086

Contact for claims inquiries: PHInfo@evicore.com

Chiropractors for Excluded Members, see Claims Contacts.

Appeals

If your request for medical necessity review is denied, you will receive information from Palladian regarding your appeal rights.

For **Commercial members**, appeals for denial determinations made by Palladian must be submitted to:

Palladian Musculoskeletal Health
Attn: UM Department
2732 Transit Roadt
West Seneca, NY 14224

For **Medicare members**, appeals for denial determinations made by Palladian must be submitted to EmblemHealth as described in the Dispute Resolution for Medicare Plans chapter of this Provider Manual.