Provider Manual

Updated January 1, 2022

PERENNIAL ADVANTAGE

Personalized attention.
Better living.

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Plan Overview

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at https://PerennialAdvantage.com. The information contained in the manual is current as of the January 1, 2022.

The provider manual contains policies, procedures, regulatory/contractual requirements to support you our providers in providing comprehensive care to our members and understanding our programs and processes.

Any reference to *providers* refers to contracted (i.e., in-network) providers unless otherwise indicated.

The terms member, patient, and customer are used interchangeably to refer to the recipient of healthcare services.

Introduction

Perennial Advantage ("health plan" or "Plan") is a Medicare Advantage HMO Plan.

There are different types of Medicare health plans. Perennial Advantage is a Medicare Advantage Special Needs Plan (SNP), which means its benefits are designed for people with special health care needs.

Perennial Advantage offers two types of SNPs:

- Perennial Advantage is an HMO Institutional Special Needs Plan (I-SNP) designed to improve the care for the residents of Nursing Facilities in Ohio and Colorado.
- Perennial Advantage is an HMO Chronic Condition Special Needs Plan (C-SNP) tailored for individuals who have one or more disabling chronic conditions such as cardiovascular disorders (i.e., cardiac arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder), chronic heart failure or diabetes.

Some important things to remember about Medicare SNP members:

- A SNP member is still covered by Medicare and has chosen to get their Medicare health care and prescription drug coverage through our plan.

- A SNP member still has Medicare rights and protections.
- A SNP member gets supplemental benefits from the plan. Supplemental benefits are not covered under Part A, Part B, or Part D.
- A SNP member's benefits, provider choices, and drug formularies (list of covered drugs) are tailored to best meet their specific needs.
- A SNP member typically requires a deeper level of care coordination.
- SNPs focus more on specific lifestyle care management needs with specialized expertise tailored to members' needs.

Our Model of Care

The Plan's Model of Care provides patient-centered, primary care driven care experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, the Model of Care is designed to improve the quality of life for members while providing access to same services covered by Original Medicare. Supplemental benefits offer additional services and support for the Plan's specialized population. The SNP MOC plan training can be located here: http://perennialadvantage.com/wp-content/uploads/2021/12/2022PER_Model-of-Care.pdf

Goals of the Perennial Advantage

- Improve access to medical, mental health, and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact;
- Improve transitions of care across health care settings and providers;
- Improve access to preventive health services;
- Assure appropriate utilization of services; and
- Improve member health outcomes.

Participating providers should know:

1. All members are required to choose or designate a Primary Care Physician (PCP) at enrollment. The staffing model, which could include care provided by a Nurse Practitioner (NP) or Physician Assistant (PA) is described in the Model of Care.

2. All members are assigned a Medical Concierge who will help to ensure coordination of services and efficient communication between providers and among provider, caregivers, and members.

3. The Plan has received permission from CMS to waive the 3-day hospitalization stay required before providing skilled nursing services (SNF). This is important because it allows skilled nursing homes, with approval from the member's PCP, to treat members in the nursing home when appropriate and reserves acute hospital stays for members requiring more intensive services.

4. Perennial Advantage uses a gatekeeper model, meaning referrals should be approved in advance by the member's PCP. This approach aids in care coordination and claims payment.

5. The Plan is "provider friendly" and strives to reduce unnecessary paperwork whenever possible. Providers are encouraged to be familiar with the claims, notification, prior authorization and referral processes outlined in this manual.

Working with the Plan

Key Contacts

Member Services Department

- **CO:** 1-844-788-6959 (TTY 711), option #1
- **OH:** 1-844-788-6986 (TTY 711), option #1

Plan's Provider Services Department

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2

Member Identification & Eligibility

All participating providers are responsible for verifying a member's eligibility during each visit, or before the appointment.

Perennial Advantage has the most current eligibility information. You can verify member eligibility through the following ways:

- **Via Member ID Card:** Note that changes do occur, and the card alone does not guarantee member eligibility.
- **Via Provider Web Portal:** Perennial Advantage web portal allows providers to verify eligibility online 24/7 at https://perennialadvantage.com/providers
- **Call Provider Services Department**

Please note membership data is subject to change. The Centers for Medicare and Medicaid Services (CMS) may retroactively terminate members for various reasons and recoup payments it made to the plan. When this occurs, Perennial Advantage claims recovery unit will request a refund from the provider for any services furnished when the member was ineligible. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question. Typically, the beneficiary is disenrolled to Medicare fee-for-service. If the Medicare timely filing period has passed, Federal law gives providers an extra six months after the plan's recoupment to file a claim.

Benefits and Services

All Perennial Advantage members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and Services are subject to change on January 1st of each year. Providers may contact the Provider Services line for information on covered services and verification of applicable member copayments and/or cost sharing owed by the member to the provider for the provision of services.

All participating providers are obligated to bill and collect applicable member copayments and/or cost sharing as defined under the Perennial Advantage policy or CMS regulations. Participating providers of Perennial Advantage are however, prohibited from balance-billing members copayments and/or cost sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information refer to MLN Article SE1128, or visit: http://www.cms.gov/MLNMattersArticles/Downloads/SE1128.pdf.

Emergent and Urgent Services

Perennial Advantage follows the Medicare definitions of "emergency medical condition", "emergency services", and "urgently-needed services" as defined in the Medicare Managed Care Manual Chapter 4 Section 20.2:

Emergency medical condition: "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part."

Emergency services: "Covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition."

Urgently-needed services: "Covered services that are not emergency services as defined above but:

- Are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
- Are provided when the member is temporarily absent from the plan's service area or under unusual and extraordinary circumstances when the member is in the service area, and the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services through the Plan network."

The Perennial Advantage network includes multiple hospitals, emergency rooms, and providers able to treat the emergent conditions of Perennial Advantage members twenty-four (24) hours a day, seven (7) days a week. Emergent services should be obtained from the closest facility that can provide the service. All emergency and urgently needed services may occur without prior authorization or referrals. For emergent issues occuring onsite in the member's nursing home or in the service area, the PCPs is generally responsible for providing, directing, or facilitating a member's emergent care. This includes emergent services provided onsite in the nursing facility ("treatment in place"). The PCPs or his/her designee must be available 24 hours a day, 7 days a week to assist members needing emergent services.

Emergent issues requiring services or expertise not available onsite in the member's nursing home are addressed by transferring the member to an acute care hospital or emergency room able to provide the needed care. The PCPs, working with the Plan's PCP, is generally responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the Member. Members may have a copayment responsibility for outpatient emergency visits unless it results in an admission.

While most members remain in the service area, Perennial Advantage members may receive emergency services and urgently needed services from any provider regardless of whether services are obtained within or outside Perennial Advantage authorized service area or network. In unusual circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible, prior approval is needed and will be approved for only continuity of care.

Perennial Advantage network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent, the Plan follows Medicare rules on coverage for ambulance services as outlined in 42 CFR 410.40. Due to the emergency medical condition, members are only liable for the applicable cost sharing.

Excluded Services

In addition to any exclusions or limitations described in the members' Evidence of Coverage (EOC), the following items and services are not covered under the Original Medicare Plan or by Perennial Advantage:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan.
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
- Orthopedic shoes, unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Supportive devices for the feet (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC.
- Routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services, and eyeglasses (which are only covered after cataract surgery) unless otherwise specified in the EOC.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy unless otherwise included in the member's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures and non-prescription contraceptive supplies.
- Naturopathic services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergencies received at a VA hospital, if the VA cost sharing is more than the cost sharing required under the Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan cost sharing amount.

Continuity of Care

Perennial Advantage's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. As such, participating providers must notify the plan when they are terming or wish to term the Perennial Advantage plan network. This will ensure Perennial Advantage is able to provide patients at least 30 calendar day advance notice of a provider termination where possible. When advance notice to Perennial Advantage is not possible, please notify the plan as soon as possible.

When a practitioner leaves Perennial Advantage's network and a member is in an active course of treatment, our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

If the Plan terminates a participating provider, Perennial Advantage will work to transition a member into care with a Participating Physician or other provider within Perennial Advantage's network. Perennial Advantage is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Perennial Advantage also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in Perennial Advantage's network. Under these circumstances, Perennial Advantage will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

Perennial Advantage will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Provider Services at

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2

Referrals

Perennial Advantage uses a gatekeeper model, meaning referrals and testing should be reviewed in advance by the member's PCP to help in care coordination.

A member's PCP may make referrals for in-network specialists. Whenever possible, in-network specialists are encouraged to provide member visits in the member's nursing facility for safety and comfort. All specialist physician services must be approved by the member's PCP.

Whether the referral originates with the PCP, or specialists, referrals should be made to Perennial Advantage participating physicians/facilities. **The PCP must approve the referral.**

Referrals to "out of network" physicians or facilities require prior authorization from the Plan's Utilization Management team. Out of network referrals may be allowed in certain circumstances where in-network providers or continuity of care concern (see section on Continuity of Care).

Notification of Inpatient and Observation Admissions

For timely care coordination, Perennial Advantage requires notification as soon as reasonably possible within one (1) business day for the following services:

- Elective Admissions
- ER and Urgent-Direct Admissions
- Observation Status
- Admissions following outpatient procedures or Observation status
- Transfers to Acute Rehabilitation, Skilled Nursing, and Long-term Acute Care (LTAC) facilities

For notification of admission or transfer, providers should call Provider Services:

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2

Emergent admission notification must be received within one business day of admission. For observation stays, Perennial Advantage expects hospitals (including critical access hospitals) to furnish the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though Perennial Advantage waives the three-day stay requirement.

Prior Authorization

Requests for prior authorizations of services should be made before or at the time of scheduling the service. The PCP, and Specialists are responsible for requesting prior authorization for the services they order. Facilities may also request prior authorizations for scheduled admissions, elective admissions, procedures, and outpatient services ordered by the PCP.

Perennial Advantage recommends calling at least fifteen (15) days in advance of an elective admission, procedure, or service. Requests for prior authorization will be prioritized according to the level of medical necessity. For prior authorizations, providers should email or call:

- **Email:** UMInquiryRequest@allyalign.com
- **Call:**
    - **CO:** 1-844-788-6959 (TTY 711), option # 2
    - **OH:** 1-844-788-6986 (TTY 711), option #2

Services Requiring Prior Authorization

Providers should refer to the provider section of the plan's website at https://PerennialAdvantage.com, for a listing of services typically requiring referral or authorization

Documentation for Prior Authorizations

The Utilization Management Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes the authorization determination, and notifies the provider and member of the determination. Examples of information required for a determination include, but are not limited to:

- Member name and identification number
- Location of service (e.g., hospital or outpatient surgical center setting)
- PCP
- Servicing/Attending physician name
- Date(s) of service
- Number of visits, if applicable
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code

- Clinical information supporting the need for the service

Decisions and Time Frames

Expedited: When you as a provider believe waiting for a decision under the routine time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you may request an expedited request. Expedited medical service requests will be determined within 72 hours or as soon as the member's health requires. Expedited requests for Part B drug services will be determined with 24 hours.

Routine/Standard: If all required information is submitted at the time of the request, CMS generally mandates a health plan determination within 14 calendar days.

Once the Utilization Management Department receives the request for authorization, Perennial Advantage will review the request using nationally recognized industry standards or local coverage determination criteria. If the request for authorization is approved, Perennial Advantage will assign an authorization number and enter the information in the Plan's medical management system.

The authorization number is only used for reference, it does not signify approval. **Claims for services requiring prior authorization must be submitted with the assigned authorization numbers.** This authorization number can be used to reference the admission, service, or procedure.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital, rehabilitation, SNF, or other inpatient admission, any services which are continued after the initial service has been approvedto ensure:

- Covered services are provided at the appropriate level of care; and
- Services are administered according to the individual facility/vendor contract

Utilizing CMS guidelines and Milliman Care Guidelines (MCG) to review criteria, Perennial Advantage's Utilization Management department and the Plan's Medical Directors will conduct a medical necessity review. Perennial Advantage is responsible for final authorization.

Perennial Advantage's preferred method for concurrent review is a live dialogue between our Utilization Management nursing staff and the facility UM staff within 1 Business Day of

notification or on the last covered day. If clinical information is not received within 24 hours of admission or prior to the last covered day, an administrative denial may be issued, or the medical necessity will be made on the existing clinical criteria. If it is not feasible for the facility to contact Perennial Advantage via phone, facilities may fax the member's clinical information within one business day of notification to:

- Fax**:** 1-833-610-2399

Specific to the ISNP: UM Review is not required for readmission to the referring NF (the member's primary nursing facility); however, if the patient is transitioning to an alternate facility, requests for review should be faxed to:

- Fax**:** 1-833-610-2399

A Perennial Advantage Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF stays that do not meet medical necessity criteria and issues a determination. If the Perennial Advantage Medical Director deems the inpatient or SNF confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The Utilization Management nurse or designee will notify the provider(s), e.g. facility, attending/ordering provider verbally and in writing and will notify the member as required by law. The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made, please contact Provider Services:

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2

For members receiving hospital care and for those who transfer to a non-referring SNF or Acute Inpatient Rehabilitation Care, Perennial Advantage will approve the request or issue a denial if the request is not medically necessary, or if there is a contracted facility that can provide the care. Perennial Advantage will also issue a denial if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the members' or their authorized representatives' right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

Perennial Advantage also issues written Notice of Medicare Non-Coverage (NOMNC) determinations by CMS guidelines. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the

member, authorized representative or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is expected to fax a copy of the signed NOMNC back to Utilization Management Department at the number provided. The NOMNC includes information on members' rights to file a fast-track appeal. **Capitated Nursing Facilities must continue to follow their standard NOMNC process for capitated services. The Plan will not generate these NOMNCs.**

Rendering of Adverse Determinations (Denials)

In some instances, the Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, non-covered or exhausted benefits, or eligibility. Late authorization, or not providing clinical information as requested, will result in an administrative adverse determination, and does not allow the provider to appeal.

Only a Perennial Advantage Medical Director, or delegated physician, may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines. When making a decision based on medical necessity, the Plan requests necessary information, including pertinent clinical information from the treating provider, to allow the Medical Director to make appropriate determinations. The Medical Director may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, Perennial Advantage notifies the facility or provider's office of the denial of service. Notices are issued to the provider, the member, or the member's authorized representative documenting the original denied request and the alternative approved service, along with the process for appeal, according to CMS guidelines.

Perennial Advantage employees are not compensated for denial of services. The PCPs or Attending Physician may contact the Medical Director by telephone to discuss decisions only before an adverse determination is rendered.

After the adverse determination is rendered, the decision may not be changed unless an appeal is initiated.

Notification of Adverse Determinations (Denials)

The reason for each denial, including the specific utilization review criteria with pertinent subset/information or benefits provision used in the determination of the denial, is included in

the written notification and sent to the provider and/or member as applicable. Written notifications are sent to the members, as applicable and requesting provider as follows:

- For non-urgent pre-service decisions-within 14 calendar days of the request.
- For urgent medical service decisions–*within 72 hours of the request.
- For urgent Part B drug services decisions–*within 24 hours of the request.
- For urgent concurrent decisions–*within 24 hours of the request.

**Denotes initial oral notification of the denial decision is provided with electronic or written notification given no later than three calendar days after the oral notification.*

Perennial Advantage complies with CMS requirements for written notifications to members, including rights to file appeals and grievances.

Billing and Claims

Claims Submission

While Perennial Advantage prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact your local Perennial Advantage Provider Services at:

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2

Perennial Advantage also offers the ability to submit claims through EZNet. Instructions on how to gain access to the portal can be found on the plan website: https://perennialadvantage.com/providers

Forward all completed paper claims forms to the address noted below:
Perennial Advantage
P.O. Box 21593
Eagan, MN 55121

Timely Filing

As a Perennial Advantage participating provider, you have agreed to submit all claims within 365 days from the date of service or within the timeframe outlined in your provider agreement with Perennial Advantage.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: cms.gov/manuals/downloads/clm104c12.pdf.

Perennial Advantage can only pay claims which are submitted accurately. The provider is always responsible for accurate claims submission. While Perennial Advantage will make its best effort to inform the provider of claims errors, ultimately claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and receive payment as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and receive payment as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated diagnoses. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties may bill and receive payment without regard to their membership in the same group.

Claim Payment

Perennial Advantage pays clean claims according to contractual requirements. A clean claim is a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, a lack of data fields or substantiating documentation required by Perennial Advantage, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim.

Pricing

Original Medicare typically has market adjusted prices by code (i.e., CPT or HCPCS) for the services traditional Medicare covers. However, there are occasions where Perennial Advantage offers a covered benefit for which Medicare has no pricing. To expedite claims processing and payment in these situations, Perennial Advantage will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. Perennial Advantage requests you make every effort to submit claims with standard coding. As described in this Manual and/or

your Agreement, you retain your rights to submit a Request for Reconsideration if you feel the reimbursement is incorrect.

Perennial Advantage will apply correct coding edits, MPPRs as outlined by CMS in the RVU table. Perennial Advantage will also follow guidelines put forth by the AMA CPT, and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances. All editing applied by Perennial Advantage is subject to the appeals/payment dispute, and clinical review policies and procedures outlined in this manual.

New or Unlisted Codes

From time to time, providers may submit codes that are not recognized by the claims system. This can happen when new codes are added by CMS for new and newly approved services or procedures, or if existing codes are changed. Providers should not bill with terminated or deleted CPT or HCPC codes.

Perennial Advantage follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code, Perennial Advantage will load the new code as made available.

In the event a provider submits a code and Perennial Advantage claims system does not recognize it as a payable code or does not have a contracted allowance, the following process applies:

- Perennial Advantage maintains the right to review and/or deny any claim with CPT/HCPC codes that are not recognized by the system. Supporting documentation may be requested to substantiate services, determine allowance basis, and to make a coverage determination. Examples include but are not limited to, new CPT/HCPC codes, not otherwise classified codes, and codes designated as Carrier Defined by CMS;

- The provider may dispute the denial as outlined in their contract, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and

- Perennial Advantage will pay for any services that include proof of payment by Original Medicare within the past six (6) months at the provider's contract rate or, if not addressed, 100% of the current Medicare rates less all applicable copayments, deductibles, and cost-sharing for which the provider furnishes proof.

- Providers may submit documentation of payment for new services/codes with original claims to prevent the need for an initial denial and subsequent appeal and re-adjudication process.

- All codes/services submitted for payment but not recognized by the claims system will be subject to verification of medical necessity. **Providers should always call for prior authorization of any procedure/service/or code for which they have concerns about coverage.**

HEDIS Coding Tips

CPT Category II codes, when added to a claim, help identify additional information about the member's care. This method of reporting simplifies and improves accuracy of reporting select quality measures for HEDIS®, CMS Star Ratings reporting and incentive programs. Category II codes are for informational purposes only and this communication is not intended to suggest or guide reimbursement. Reach out to Provider Services if you would like additional information.

Claims Encounter Data

Providers who are paid under capitation must submit claims within the same timely filing limit required in their provider agreement with Perennial Advantage or non-capitated claims to capture encounter data as required per your Perennial Advantage Provider Agreement.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the provider after Perennial Advantage has determined coverage and payment. The statement provides a detailed description of how the claim was processed.

Non-Payment/Claim Denial

Any denials of coverage or non-payment for services by Perennial Advantage are addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed for each billed line if applicable. An explanation of all applicable adjustment codes per claim are listed below that claim on the EOP/RA. Per your contract, the member may not be billed for services denied by Perennial Advantage unless the member received the denial **before** the service was provided and the member indicated they wanted to receive the services regardless of coverage. The member may not be billed for a covered service when the provider has not followed Perennial Advantage's procedures. In some instances, providing the needed information may reverse the denial (i.e., referral form with a copy of the EOP/RA, authorization

number, etc.). When no benefits are available for the member or the services are not covered, the EOP/RA will alert you to this.

Obtaining pre-services review will reduce denials.

Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice, the financial responsibility for that member shifts from Perennial Advantage to Original Medicare. Original Medicare retains payment responsibility for all hospice and non-hospice related claims for traditional Medicare benefits beginning on the date of the hospice election.

The only services Perennial Advantage is financially responsible for during this time include any supplemental benefits Perennial Advantage offers in addition to Original Medicare benefits.

Members can revoke hospice elections at any time. If so revoked and once notified by CMS, the Plan will resume coverage for the member the first of the following month. These rules apply for both professional and facility charges.

Perennial Advantage may be notified of a hospice election by CMS after claims have been paid for dates of service during the hospice election period. In this instance, the Plan will notify the provider that a refund is due to the Plan. The provider must remit the refund to Perennial Advantage and submit a claim for these services to Original Medicare, consistent with CMS policies.

Subrogation

Subrogation is the coordination of benefits between a health insurer and a third-party insurer (i.e., property and casualty insurer, an automobile insurer, or worker's compensation carrier), not two health insurers.

Claims involving Subrogation or Third-Party Recovery (TPR) will be processed internally by Perennial Advantage Claims Department.

Members who may be covered by third-party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to Perennial Advantage with any information regarding the third-party carrier. All claims are processed per the usual claims' procedures.

For claims related questions, please contact your local Perennial Advantage Provider Services Department at:

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2

A Network Services Representative will gladly assist.

Appeals and Payment Disputes

Provider Claims Payment Dispute

If your claim was paid and you dispute the payment amount, please follow this process. Payment dispute procedures are separate and distinct from appeal procedures. A formal payment dispute request is required from the Provider to contest a paid amount on a claim which does not include a medical necessity or administrative denial.

All Payment Disputes must be:

- Submitted in writing within 60 days from the original payment
- Include a cover letter with:
    - Claim Identifiable information
    - The specific rationale as to why the payment made is not appropriate or needs adjustment
- Include necessary attachments:
    - Copy of the original Remittance Advice (RA)
    - All applicable medical records or other attachments supporting additional payment

Providing the above information enables the Payment Dispute Unit to properly and promptly review the request. Requests that do not follow all of the above may delay resolution Perennial Advantage will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment.

The appeal must be in writing and mailed or fax to:
Address: Perennial Advantage Appeals Department, PO Box 2190, Glen Allen, VA 23058
Fax: 1-833-610-2380

Providers will be notified of the final outcome.

Participating Provider Administrative Plea/Appeals Responsibility

A provider may submit a formal request to review a previous decision where a determination was made stating the Participating Provider failed to follow administrative rules, assigning liability to the Provider (see original decision letter) where the services were rendered.

All requests must be:

- Submitted in writing
- Submitted within 60 days from the decision letter date
- Include a cover letter with:
    - Member Identifiable information
    - Date(s) of service in question
    - The specific rationale as to why the administrative rules were not followed,
    - requiring an exception to be made or extenuating circumstance warranting a rereview of the request for provision of payment.
- Include necessary attachments:
    - Copy of the original decision
    - All applicable medical records

The appeal must be in writing and mailed or fax to:
Address: Perennial Advantage Appeals Department, PO Box 2190, Glen Allen, VA 23058
Fax: 1-833-610-2380

In the event Perennial Advantage waives the administrative requirement, and the request requires a medical review, Perennial Advantage will not request additional records to support the provider's argument. The provider is expected to submit the necessary information to substantiate the request for payment.

Providers will be notified of the final outcome.

Member Grievances and Appeals

Appeals

Members of Perennial Advantage have the right to appeal any decision about Perennial Advantage's failure to provide or pay for what they believe are covered services.

These include, but are not limited to:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide;
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by Perennial Advantage;
- Services they have not received, but believe are the responsibility of Perennial Advantage to pay; and/or
- A reduction in or termination of service a member feels is medically necessary.

Also, a member may appeal any decision to discharge from the hospital. In this case, a notice will be given to the member with information about how to appeal. The member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to Perennial Advantage's Evidence of Coverage (EOC) for additional information.

For pre-service determinations, the enrollee's treating physician acting on behalf of the enrollee or staff of the physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead); or any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding may file an appeal.

An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also "partial" ones). Appeals will receive an independent review (made by someone not involved in the initial decision). Requesting an appeal does not guarantee the request will be approved, or the claim paid.

The appeal decision may still be to uphold the original decision.

A request for a standard appeal must be submitted to the address/fax listed below within 60 days from the original decision. Appeal requests should include a copy of the denial, and any medical records supporting why the service is needed.

A request for an expedited appeal (pre-service requests only) may be filed orally or in writing. To request an expedited appeal orally, please call:

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2

An enrollee or physician may request an expedited appeal where they believe deciding within the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Providers contracted with Perennial Advantage may not use the member appeal process to file an appeal for post-service payment disputes. Contracted providers should use the process outlined in the "Billing and Claims" section of this manual or in their provider agreement if they believe a claim was denied for payment in error or if there are additional circumstances the Plan should consider.

- Part C Appeals Phone:
  - **CO:** 1-844-788-6959 (TTY 711), option #2
  - **OH:** 1-844-788-6986 (TTY 711), option #2
- Part C Appeals Fax: 1-833-610-2380

Member Grievances

Members of Perennial Advantage have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

- Complaints regarding issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns;
- Involuntary disenrollment situations; and/or
- Complaints concerning the quality of services a member receives.

Complaints may be received by the Plan's PCP, Contracted Facilities, Plan Customer Service representatives, and through Member Services. All complaints are logged, categorized, and worked to resolution per CMS guidelines for Medicare Advantage plans.

Complaints or grievances should be reported to Member Services. Providers must cooperate with Perennial Advantage in investigating grievances related to the provider or providers services.

Provider Information

Provider Credentialing

Perennial Advantage does not discriminate in terms of participation, reimbursement, or based on the population of beneficiaries serviced, against any health care professional who is acting

within the scope of his or her license or certification under state law. All practitioners and organizational applicants to Perennial Advantage must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider.

No provider can be assigned an effective date with Perennial Advantage, be included in the Plan Provider Directory, or have Perennial Advantage Members assigned to them without having successfully completed the credentialing process.

Application Process

If you are not yet a contracted provider and would like to join our network, please contact provider services at Perennial Advantage. Note that network participation decisions are based on network needs.

In order to begin the credentialing process, providers must be contracted and submit a completed and signed credentialing application to Perennial Advantage. The application can be a State Mandated Credentialing application, a CAQH Universal Credentialing Application form or CAQH ID, or the Plan's application with a current signed and dated Attestation and Consent and Release form that is less than 90 days old.

Send completed credentialing applications to:

- **CO:** perennialco@allyalign.com
- **OH:** perennialoh@allyalign.com

Credentialing and Recredentialing Process

Once a Provider has applied for initial consideration, Perennial Advantage's Verification Organization or its designee will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, and malpractice history by querying the National Practitioner Data Bank.

The credentialing process can take up to 90 days to complete. Once credentialing has been completed, and the applicant is approved, the Practitioner will be notified in writing of their participation effective date.

All practitioners are required to recredential at least every three years to maintain an active participating status with Perennial Advantage. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit re-credentialing information at least four months in advance of their

three-year anniversary date. Three separate attempts will be made to obtain the required information via mail, fax, email or telephonic request. Practitioners who fail to return recredentialing information before their re-credentialing due date will be notified in writing of their termination from the network.

Provider Rights

Providers have the right to review information obtained from any outside source to evaluate their credentialing application except references, recommendations or other peer-review protected information, also known as primary source recommendation. The provider may submit a written request to review his/her file information at least thirty days in advance. The Plan will establish a time for the provider to view the information.

Providers have the right to correct erroneous information when information obtained during the credentialing process varies substantially from what was submitted by the provider. In instances where there is a substantial discrepancy in the information, Perennial Advantage will notify the provider in writing of the discrepancy. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within 30 days of notification.

Providers have the right to be informed of the status of their application and may request the status of the application either telephonically or in writing. Perennial Advantage will respond within ten (10) business days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status.

Facility/Organizational Provider Selection Criteria

When assessing organizational providers, Perennial Advantage utilizes the following criteria :

- Must be in good standing with all state and federal regulatory bodies
- Has been reviewed and approved by an accrediting body if applicable
- If not accredited, can provide copy of a recent CMS site survey or evidence of successfully passing a recent CMS site survey.
- Maintains current professional and general liability insurance as applicable
- Has not been excluded, suspended and/ or disqualified from participating in any Medicare, Medicaid, or any other government health-related program
- For “providers of services” under section 1861(u) of the Social Security Act, must have a provider agreement with CMS permitting them to provide services under original

Medicare; is not on the precluded provider list. Note that the accreditation requirement does not apply to all organizational types, if it is required, the plan will request it during the application process.

Facility/Organizational Provider Application Requirements

In order to begin the facility credentialing process, the following must be submitted:

- A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
- If responded "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.
- Copies of all applicable state and federal licenses (i.e., facility license, DEA, Pharmacy license, etc.).
- Proof of current professional and general liability insurance as applicable.
- Proof of Medicare participation.
- Copy of DEA Registration.
- If accredited, proof of current accreditation.
- If not accredited, a copy of any state or CMS site survey that has occurred within the last three years.

Credentialing Committee/Peer Review Process

All initial applicants and re-credentialed providers are subject to a peer review process before approval or reapproval as a participating provider. The Credentialing Committee is composed of plan providers of different specialties and professional backgrounds. Each plan selects a Medical Director to represent the plan. The Plan Medical Director may approve providers who meet all of the acceptance criteria. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of primary care and specialty providers and has the authority to approve or deny an appointment status to a provider. All providers must be credentialed and approved before participating in the plan's network.

Non-Discrimination in the Decision-Making Process

Perennial Advantage's Credentialing Program is compliant with all CMS and State regulations as applicable. Through the universal application of specific assessment criteria, Perennial Advantage ensures fair and impartial decision-making in the credentialing process. No provider

is participation based solely on race, gender, age, religion, ethnic origin, sexual orientation, type of population served or for specializing in certain types of procedures.

Provider Notification

All initial applicants who complete the credentialing process are notified in writing of their credentialing approval date. Providers are advised not to see Perennial Advantage members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee are notified in writing within sixty (60) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process & Notification of Authorities

In the event a provider's participation is limited, suspended or terminated, the provider is notified in writing within 60 days of the decision. Notification includes a) the reason(s) for the action, b) the appeals process or options available to the provider, and c) provides the time limits for submitting an appeal. A panel of peers review all appeals. When termination or suspension is the result of quality deficiencies, the appropriate state, and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and re-credentialing process is considered confidential, handled and stored confidentially and securely as required by law and regulatory agencies. Confidential practitioner credentialing and re-credentialing information is not disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing Monitoring

Perennial Advantage conducts routine, ongoing monitoring of the preclusion list, license sanctions, Office of Inspector General (OIG) exclusions, Medicare/Medicaid sanctions and the CMS Opt-Out list between credentialing cycles. Any provider whose license has been revoked or has been precluded, excluded, suspended and disqualified from participating in any Medicare, Medicaid or any other government health-related program or who has opted out of Medicare will be automatically terminated from the Plan.

Site Evaluations

Site evaluations may be required when it is deemed necessary as a result of a customer complaint, quality of care issue and/or as otherwise mandated by State or Federal regulations. Office site evaluations will review the following:

- Physical appearance and accessibility.
- Customer safety and risk management.
- Medical record management and security of information.
- Appointment availability.
- Cleanliness & Adequacy of Equipment
- Policies and Procedures

Providers who fail to pass the area of the site visit specific to the complaint or who do not meet the site evaluation standards will be required to submit a corrective action plan and make corrections to meet the requirements. Follow up reviews may be conducted to ensure compliance.

Provider Directory

To be included in Provider Directories or any other member information, providers must be fully credentialed and approved and must be credentialed under a specialty or capability required for Online Provider Directory display by CMS. Directory specialty designations must be commensurate with the education, training, board certification and specialty(s) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by Credentialing and Recredentialing Process of the Plan.

Plan Notification Requirements for Providers

The following list of changes must be reported to Perennial Advantage at least thirty (30) days in advance (or longer as stated in the provider agreement) by emailing:

- **CO:** perennialco@allyalign.com
- **OH:** perennialoh@allyalign.com

Provider Termination (inclusive of but not limited to: retirement, moving out of service area, no longer accepting Medicare, group termination)

- Practice address

- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Provider joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions
- Adding or closing a practice location
- Tax Identification Number (please include W-9 form)
- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations
- Panel status changes (closed or open panel)
- Office Hour updates

By providing this information promptly, you will ensure your practice is listed correctly in the Provider Directory.

Closing Patient Panels

When a participating PCP elects to stop accepting new patients, the provider's patient panel is considered closed. If a participating PCP closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against Perennial Advantage members by closing their patient panels for Perennial Advantage members only. Providers who decide they will no longer accept any new patients must notify Perennial Advantage at least 30 days prior to the change effective date.

Access and Availability Standards for Providers

Perennial Advantage has established written standards to ensure timeliness of access to care that meets or exceed the standards established by CMS, to ensure all standards are communicated to providers, to continuously monitor compliance with the standards, and to take corrective action as needed. Perennial Advantage also requires all providers to offer standard hours of operation that (1) do not discriminate against Medicare enrollees, and (2) are convenient for Perennial Advantage members, the facilities where members reside, and facility staff who aid in member care. PCPs are NOT to provide routine visits at times that coincide with regular facility meal times, or interfere with expected member sleep patterns by occurring before 8 am or after 8 pm, or occur during nursing staff shift changes.

Access and Availability Survey

Perennial Advantage conducts monitoring of provider access and availability to ensure compliance with CMS standards. The Access and Availability yearly survey is used to review provider compliance with access standards.

The Access and Availability survey is an online survey sent to providers as a link for completion. The survey includes multiple choice questions depending on the provider specialty type. Providers must obtain at least an 80% score to pass the survey. Providers that fail the survey are sent a corrective action notice which allows them the opportunity to identify the corrections needed and include remediation actions with due date. A resurvey is conducted after the due date.

Provider Responsibility

- Perennial Advantage members have access to care 24 hours a day, 7 days a week as medically necessary. Perennial Advantage has additional policies in place to make sure members have timely access to regular and routine care services, urgent care services, preventative care, network providers, women's health services, or after-hours care. PCPs are required to provide routine, preventive care and monitoring visits for their assigned members on-site at the member's nursing facility residence every 60 days for all members and more frequently (every 30 days) for members identified as a moderate or high risk.
- Assigned providers must make routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within one week (7 days) on-site at member's nursing facility residence.
- Immediate urgent and emergent care on-site at member's nursing facility residence or in the physician's office or telephonically in coordination with the Nurse Practitioner.
- 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician coverage during time off (call coverage), with emergency care calls, both weekdays or after-hours, responded to immediately; urgent care calls, weekdays and after-hours, responded to within 30 minutes; and routine care calls returned by the end of the day.
- Specialists are required to be available for a consult or new patient appointment within 21 days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding a member.
- Telephone Access (applicable to all contracted providers regarding calls from members, members' caregivers, Perennial Advantagee PCP, Perennial Advantage Medical Director and Utilization Management staff, and nursing home facility staff):

- Emergency care calls, both weekdays and after-hours calls, are to be addressed immediately. Urgent care calls, both weekdays and after-hours calls, are returned within 30 minutes.
- Routine care calls, both weekdays and after-hours calls, will be returned promptly. All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.

Non-Discrimination and Cultural Competency

Participating providers must provide services to all plan customers, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

It is the responsibility of contracted providers to provide covered services in a culturally competent manner to plan customers and ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled.

Dual Eligibles and Cost Sharing

For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

Patient Hold Harmless

Participating Providers are prohibited from balance billing Perennial Advantage customers including, but not limited to, situations involving non-payment by Perennial Advantage, insolvency of Perennial Advantage, Perennial Advantage's breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than Perennial Advantage, acting on behalf of customers for Covered Services provided pursuant to the Participating Provider's

Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances or deductibles for covered services in accordance with the terms of the applicable customer's Benefit Plan, or for collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of the Provider Manual. Check with Perennial Advantage Provider Services to check on patients cost share responsibility if not listed on the patient ID card:

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2

Non-Covered Services

Providers may only collect fees from Members for non-covered services when the service is clearly listed as a non-covered service in the Members EOC, or the Member has been provided with a standardized written Organization Determination (OD) denial notice from Perennial Advantage prior to the item or service being rendered to the Member.

In circumstances where there is a question whether or not the Plan will cover an item or service, providers should inform Members that they have the right to request an OD prior to obtaining the service from the provider. If coverage is denied, Perennial Advantage provides the Member with a standardized written OD denial notice which states the specific reasons for the denial and informs the Member of his or her appeal rights.

Providers may not hold the members financially responsible or issue any form or notice that advises the customer they will be responsible for the costs associated with non-covered services unless the customer has already received the appropriate pre-service OD denial notice from Perennial Advantage or the service or item is explicitly stated as a non-covered service in the EOC.

Network Access Monitoring and Compliance

Using valid methodology, Perennial Advantage will collect and perform regular analyses of provider data to measure performance against the Plan's written standards. Examples of measurement tools include:

- Access and Availability Survey: Utilizes the third next available appointment methodology to survey selected high-volume and high-impact specialists like cardiology, endocrinology, neurology, ophthalmology, pulmonology, and urology for availability and appointment timeliness requirements as set forth in the provider agreement and the provider manual.

- After-hours care telephone survey: Annual survey of to measure the after-hours availability and responsiveness of providers s to routine and urgent calls.
- Member satisfaction survey: Annual survey includes questions related to accessibility and availability of network services.

In addition to regularly scheduled performance measurement, complaints related to access to care (provider or after hours) are collected through Perennial Advantage Provider Services Department line or submissions to the Quality Improvement Committee. Access complaints are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Performance consistently falling outside of written standards, with failure to make progress in corrective actions, may result in the recommendation to close primary care panels; contracting with additional practitioners or providers if needed; and adverse credentialing or contracting decisions in cases of persistent failure to make progress towards meeting standards.

Member Medical Records

Perennial Advantage participating providers are required to maintain patient medical records current and in accordance with HIPAA privacy and document retention regulations. Member information must be kept confidential and stored in a secure location where only authorized personnel can access. Patients have the right to approve or refuse the disclosure of their medical records when required by law. Providers must maintain a clinical record system that supports the capacity to properly process, store, retrieve and distribute medical records. Medical Record requirements apply to both paper and electronic record systems.

Documentation must demonstrate consistency in entries to ensure that diagnosis and treatment align with initial assessment and impressions, treatment, therapies, referrals, consultations, and continuity of follow-up care.

The following must be included in patient medical records:

- Identifying information of the customer
- Identification of all providers participating in the customer's care and information on services furnished by these providers
- Significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses, and treatment plans
- Prescribed medications, including dosages and dates of initial or refill prescriptions, including over-the-counter products and dietary supplements

- Information on allergies and adverse reactions
- Past medical history, physical exams, courses of treatment and possible risk factors.
- Patient immunization records
- Labs, X-ray, and all studies
- Indicate patients preference for a Power of Attorney
- Include a copy of patient's advance directive if one is available
- Health education and wellness promotion services accessed by members
- Provision of significant medical advice given by telephone, including medical advice provided by after-hours information or triage services

Unless otherwise stated in the provider agreement, Perennial Advantage has the right to request and access Perennial Advantage patient medical records for the purposes of claim payment, quality of care, coordinating treatment plans, utilization management reviews or as part of a CMS, state or federal audit.

Provider Marketing Guidelines

The below is a general guideline to assist Perennial Advantage providers in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limiting to a number of plans offered either by the plan sponsor or another sponsor based on the financial interest of the provider or agent. Providers should remain neutral parties to the extent they assist beneficiaries with enrollment decisions. Please consult the CMS Marketing Guidelines or other CMS published materials for the full list of acceptable and unacceptable provider behaviors.

Definitions

- **Permission to Contact –** documentation that a beneficiary or responsible party has requested additional information about the health plan
- **Scope of Appointment –** documentation of a sales appointment with a beneficiary, signed before any benefits discussion. The document serves to ensure no other types of products are discussed outside of what the beneficiary originally requested and states there is no obligation to enroll into the plan
- **Enrollment Application –** form that must be signed by a beneficiary (or Power of Attorney) in order to enroll into the health plan

Providers Can:

- Suggest looking into Plan membership as a matter of course in treatment.
- Collect a Permission to Contact if a resident/responsible party voices interest in learning more about the Plan.
- Pass a Permission to Contact to a sales agent.
- Mail or provide a letter to patients notifying them of their affiliation with Perennial Advantage.
- Provide objective information to patients on specific plan attributes and formularies, based on a patient's medications and healthcare needs in the course of treating the patient.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered).
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPs), Perennial Advantage marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Provide beneficiaries with communication materials furnished by Perennial Advantage in a treatment setting.
- Refer patients to the plan marketing materials available in common areas.
- Display and distribute in common areas Perennial Advantage marketing materials. The office must display or offer to display materials for all participating Medicare Advantage plans if requested by the plan.
- Provide information and assistance in applying for the Low-Income Subsidy (LIS).
- Display promotional items with Perennial Advantage logo.
- Allow Perennial Advantage to have a room/space in provider offices completely separate from where patients receive healthcare services, to provide Medicare beneficiaries with access to a Perennial Advantage sales representative.

Providers Cannot:

- Offer anything of monetary value to induce enrollees to select them as their provider.
- Distribute marketing materials/applications in an exam room.
- Urge or steer towards any specific plan or a limited set of plans based on the provider's own interest.
- Collect/accept enrollment applications or scope of appointment forms on behalf of the plan.

- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are disenrolling from the health plan to encourage re-enrollment in a health plan.
- Call patients to invite patients to the sales and marketing activities of a health plan.
- Advertise using Perennial Advantage's name without Perennial Advantage's prior consent and potentially CMS approval depending upon the content of the advertisement.

Emergency/Disaster Situations

In the event of an Emergency or Disaster declaration by the President, a State Governer or an announcement of a public health emergency by the Secretary of Health and Human Services, customers should have access to providers, services and medications. When a declaration notice is received, the notice is posted to the plan website indicating the impacted state, counties, effective date and declaration expiration date.

In order to ensure customers have access to the services needed, as of the declaration effective date, the plan will:

- Waive requirements for gatekeeper referrals where applicable;
- Temporarily reduce plan-approved out-of-network cost sharing to in-network cost sharing amounts;
- Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the enrollee;
- Allow Part A and Part B and supplemental Part C plan benefits to be furnished at specified noncontracted facilities (note that Part A and Part B benefits must, per 42 CFR §422.204(b)(3), be furnished at Medicare certified facilities).
- Ensure customers have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when those customers cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy, and when such access is not routine;
- As necessary, lift the "refill-too-soon" edits; and
- Allow affected customers to obtain the maximum extended day supply, if requested and available at time of refill.

Member Assignment to New PCP or Medical Concierge

PCPs or Medical Concierge will receive regular updates of member assignments and related services and benefits. Perennial Advantage's PCP or Medical Concierge have a limited right to request a member be assigned to a new PCP or Medical Concierge. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- The member is disruptive, unruly, threatening or uncooperative to the extent his/her membership seriously impairs the provider's ability to provide services to the member, and a physical or behavior health condition does not cause the behavior mentioned above.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required patient share responsibility for services rendered to members who are not Dual Eligibles (Medicare and Medicaid).
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied through reasonable efforts, and the PCP or Medical Concierge feels the relationship is irreparably harmed, the PCP or Medical Concierge should complete the Member Transfer Request form and submit it to Perennial Advantage. Perennial Advantage will research the concern and decide if the situation warrants requesting a new PCP or Medical Concierge assignment. If so, Perennial Advantage will document all actions taken by the provider and Perennial Advantage to cure the situation, including member education and counseling. A Perennial Advantage PCP or Medical Concierge cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

A member also may request a change in PCP or Medical Concierge for any reason. The PCP or Medical Concierge change requested by the member will be effective the first (1st) of the month following the receipt of the request unless circumstances require an immediate change.

Quality of Care Concerns

Perennial Advantage is committed to ensuring members receive quality care according to recognized standards of care. Quality of Care concerns may include specific Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are defined as an adverse outcome occurring in any care setting indicative of potential inappropriate or incomplete medical care. Quality of Care Complaints are those concerns reported by members, families, or providers indicating a potential problem in the provision of quality care and services.

The purpose of identifying these concerns is to identify opportunities to improve clinical care and service. Clinical Quality Indicators include the following:

- Unplanned readmission to the hospital (within 30 days)
- Inpatient hospitalization following outpatient surgery
- Post-operative complications (including an unplanned return to the Operating Room)
- Unplanned removal, injury, or repair of organ or structure during the procedure (excludes incidental appendectomy)
- Avoidable incidences resulting in injury to the member
- Mortality review (in cases where death was not an expected outcome)

Quality complaints are categorized as:

- Access to care
- Availability of services
- Clinical quality concerns
- Provider/staff concerns

All reported Quality of Care concerns are reviewed and tracked. Perennial Advantage often requests records from providers and facilities as part of the process. The Quality Improvement Committee reviews trends related to Quality of Care concerns and may recommended actions to prevent future instances. Any action taken based on severity or trend is documented in the health plan provider record and reviewed by the Credentialing Committee at the time of re-credentialing.

Quality Improvement Program

The purpose of the Quality Improvement Program (QI Program) at Perennial Advantage is to continually take a proactive approach to assure quality care and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so the Plan may

fully realize its vision, mission, and commitment to member care. In the implementation of the QI Program, Perennial Advantage will be an agent of change, promoting innovations throughout its health plan organization, sites of care, and in the utilization of resources, including technology, to deliver healthcare services to meet the health needs of its target population. The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness, and outcome of care/services delivered to Perennial Advantage's members. Also, to provide mechanisms for continuous improvement and problem resolution.

Quality improvement activities include the following:

- Monitoring/review of provider accessibility and availability
- Monitoring/review of member satisfaction/grievances
- Monitoring/review of member safety
- Monitoring/review of continuity and coordination of care
- Clinical measurement and improvement monitoring of the SNP Model of Care and all QI activities
- Documentation, analysis, re-measurement and improvement monitoring of member health outcomes utilizing the Align360 care management platform
- Chronic Care Improvement Program (CCIP)
- Collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS)
- Participation and analysis of the Health Outcomes Survey (HOS) and Consumer Assessment of Health Plan (CAHPS) Survey, if required
- Credentialing and re-credentialing
- Provider peer review oversight
- Clinical practice guidelines
- Monitoring and analysis of under and over-utilization
- Monitoring and analysis of adverse outcomes/sentinel events
- Collection and reporting of Part C Reporting Elements
- Collection and reporting of Part D Medication Management data

PCPs each play an active role in making sure members receive the best care. Each year, Perennial Advantage will evaluate past performance and implement improvement activity. Providers and members may request a copy of the Quality Improvement Program or Annual Evaluation at any time.

Clinical Practice Guidelines

The following clinical practice guidelines are intended to support our health care team and serve as resources to ensure our providers have the most up to date, evidence-based information recommended by nationally recognized organizations.

AMDA:
The Society for Post-Acute and Long-Term Care Medicine - the standard care process in the post-acute and long-term care (PA/LTC) setting.
https://paltc.org/product-type/cpgs-clinical-practice-guidelines

COPD:
Global Strategy for the Diagnosis, Management and Prevention of COPD.
https://goldcopd.org/2021-gold-reports

Diabetes:
Standards of Medical Care in Diabetes - 2021 with a particular focus on chapter 12: Older Adults.
https://care.diabetesjournals.org/content/44/Supplement_1

Heart Failure:
2017 focused update of the 2013 Guidelines for the Management of Heart Failure.
https://www.acc.org/education-and-meetings/products-and-resources/guideline-education/heart-failure

Hypertension:
ACC and American Heart Association (AHA) guidelines for the detection, prevention, management and treatment of high blood pressure.
https://www.acc.org/guidelines/hubs/high-blood-pressure

Dementia:
Alzheimer's Association Dementia Care Practice Recommendations
https://www.alz.org/professionals/professionalproviders/dementia_care_practice_recommendations

American Psychiatric Association – Practice Guidelines on the use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia
https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426807

Osteoporosis:

2020 Clinical Practice Guidelines for Postmenopausal Osteoporosis
https://www.physiciansweekly.com/aace-releases-2020-update-clinical-practice-guidelines-for-postmenopausal-osteoporosis

Depression:
American Psychiatric Association (APA)(2019). APA Guideline For the Treatment of Depression. Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts.
https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

Preventive:
World Health Organization, Preventing and managing COVID-19 across long-term care services: Policy brief, 24 July 2020.
https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1

Centers for Disease Control and Prevention (2020). Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season
https://www.cdc.gov/mmwr/volumes/69/rr/rr6908a1.htm?s_cid=rr6908a1_w

Guidelines are provided for informational purposes only and are not meant to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgement regarding the appropriate treatment of a patient in any given case.

Utilization Reporting and Monitoring

Under – and over-utilization may indicate inadequate coordination of care or inappropriate utilization of services. Both under- and over-utilization may be harmful to the patient. Utilizing data from provider and practitioner sites, individual product lines, and the system as a whole, Perennial Advantage monitors for under- and over-utilization, analyzes data to identify the causes, and takes action to correct any issues identified. Perennial Advantage then implements appropriate interventions whenever potential problems are identified and will further monitor the effect of these interventions. Perennial Advantage also carefully ensures that its financial incentives are aligned to encourage appropriate decisions on the delivery of care to members. Perennial Advantage unequivocally promises members, providers, and employees that it does not employ incentives to encourage barriers to care and service.

Provider Feedback

Yearly provider survey

We value your feedback. On a yearly basis, the plan will send out a provider survey to all participating physicians who have a business email on file. We encourage you to fill out the survey and provide your feedback. Survey results and reviewed for needed changes of Plan operations. Send your business email information along with your NPI and full name to:

- **CO:** perennialco@allyalign.com
- **OH:** perennialoh@allyalign.com

Member Rights

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in healthcare decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. Perennial Advantage requires all participating providers to have a process in place under the intent of the Patient Self Determination Act. All providers contracted with Perennial Advantage may be informed by the member that the member has executed, changed, or revoked an advance directive. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCPs and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he or she must advise the member and Perennial Advantage. Perennial Advantage and the PCPs and/or treating provider will arrange for a transfer of care. To ensure providers maintain the required processes to advance directives, Perennial Advantage conducts periodic patient medical record reviews.

Additional Rights

The right to be treated with dignity and respect

Members are afforded appropriate privacy and treated with respect, consideration and dignity. Members have the right to be treated with dignity, respect, and fairness at all times. Perennial Advantage and its contracted providers must obey the laws against discrimination to protect members from unfair treatment. These laws say Perennial Advantage and its contracted providers cannot discriminate against members because of a person's race, disability, religion,

gender, sexual orientation, health, ethnicity, creed, age, or national origin. Providers may not discriminate against enrollees based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost sharing from a State Medicaid program. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access to facilities (such as wheelchair access). Members can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the Office for Civil Rights in their area for assistance.

The right to see participating providers, get covered services and get prescriptions filled promptly

Members will get most or all their healthcare from participating providers—the doctors and other health providers who are part of Perennial Advantage. Members have the right to choose a participating provider. Perennial Advantage will work with members to ensure they find physicians who are accepting new patients. Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to access their prescription benefit promptly. Timely access means members can get appointments and services within a reasonable amount of time. The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know about treatment choices and to participate in decisions about their healthcare

Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their healthcare. Perennial Advantage's providers must explain things in a way that members can understand. Members have the right to know about all the treatment choices that are recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether Perennial Advantage covers them. This includes the right to know about the different Medication Management Treatment Programs Perennial Advantage offers and those in which members may participate. Members have the right to be told about any risks involved in their care.

Members have the right to receive a detailed explanation from Perennial Advantage if they believe a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.

Members have the right to refuse treatment, including the right to leave a hospital or other medical facility even if their doctors advise them not to leave, and the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to make complaints

Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If members make a complaint or file an appeal determination, Perennial Advantage must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination. Members should be directed to call the Member Services Department to obtain information relative to appeals, grievances or concerns and/or coverage determinations.

Right to Receive Complete and Accurate Health Information

Members, or legally authorized designees should receive complete and accurate information concerning about their health evaluation, diagnosis, treatment, and prognosis and have the right to participate in health care decisions unless such information is contraindicated for medical reasons.

In addition to the above, members have the following rights:

- The right to maintain confidentiality of their health information
- Right to refuse to participate in research, if applicable
- Right to interpretive services, as necessary
- Rights to access information regarding advance directives, as required by state or federal laws and regulations
- Rights to access to provider credentials upon request
- Right to change providers, including Primary Care Providers (PCP) and expedite the request to change
- Right to receive information about Provider's malpractice insurance upon request
- Right to request a second opinion related to health care treatment and services

Safety and Sanitary Environments

Perennial Advantage participating providers must ensure the servicing site and equipment used is adequate to provide needed services to plan customers. In general, the servicing site must:

- Meet American with Disabilities Act (ADA) site standards
- Meet building safety standards such as but not limited to: having exit signs, fire extinguishers visible, sprinklers, etc.

- Have emergency and disaster policies in place.
- Have adequate space to facilitate treatment and prevent cross contamination
- Have designated treatment or exam rooms that provide adequate patient privacy
- Be free of obstructions to allow adequate flow of delivered services
- Have medical equipment needed for treatment cleaned, serviced routinely and functioning properly
- Have secure locations, lockboxes or storage areas to protect syringes, needles or any medical equipment from unauthorized use
- Implement infection prevention programs and appropriate hand hygiene that include provisions to report untoward events in accordance with nationally recognized standards, such as the Centers for Disease Control and Prevention (CDC)
- Implement programs to reduce and avoid medication errors and prevent falls and physical injuries
- Implement safety protocols to properly manage potential threats and hazards

Corporate Compliance Program

Overview

The purpose of Perennial Advantage's Corporate Compliance Program is to articulate Perennial Advantage's commitment to compliance with all pertinent regulatory requirements. It also serves to encourage our employees, providers and other contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Perennial Advantage's operations. Further, Perennial Advantage's Corporate Compliance Program also ensures all practices and programs are compliant with applicable laws and regulations.

Perennial Advantage and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Perennial Advantage's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members. Perennial Advantage and its employees are also committed to meeting all contractual obligations outlined in Perennial Advantage's contracts with the CMS. These contracts allow Perennial Advantage to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing Perennial Advantage's lines of business, including but not limited to, healthcare fraud, waste and abuse laws. In the event such violations occur, the Corporate Compliance

Program will promote early and accurate detection, prompt resolution, and when necessary, disclosure to the appropriate governmental authorities.

Perennial Advantage has in place, policies and procedures for coordinating and cooperating with the MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement. Perennial Advantage also has policies ensuring the Plan will cooperate with any audits conducted by CMS, the MEDIC or law enforcement or their designees.

If you have compliance concerns or questions, call Perennial Advantage Compliance Hotline toll-free at 1-844-317-9059 (TTY 711).

Fraud, Waste, and Abuse

Perennial Advantage has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network and to properly recover such overpayments. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 U.S.C. § 1395w-104 and 42 C.F.R. § 423.504(b)(4)(vi)(H), and Perennial Advantage has policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by Perennial Advantage encompasses all aspects of Perennial Advantage business and its business relationship with third parties, including healthcare providers and members. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted in the following manner:

- Anonymously by calling the toll-free Compliance Hotline at 1-844-317-9059 (TTY 711). The Compliance Hotline is a completely confidential resource for employees, contractors, agents, members, or other parties to voice concerns about any issue potentially affecting Perennial Advantage's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.
- By email at compliance@perenniadvantage.com
- By mail at: Perennial Advantage, PO Box 2190, Glen Allen, VA 23058-2190
- Directly by phone at 1-844-317-9059 (TTY 711)

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or another party that reports compliance concerns in good faith can do so without fear of retaliation.

Also, as part of an ongoing effort to improve the delivery and affordability of healthcare to our members, Perennial Advantage conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers. The analysis allows Perennial Advantage to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. Perennial Advantage will review your coding and may review medical records of providers who continue to show significant variance from their peers. Perennial Advantage endeavors to ensure compliance and enhance the quality of claims data, a benefit to both Perennial Advantage's medical management efforts and our provider community.

To meet your FWA obligations, please review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.

You may request a copy of Perennial Advantage Compliance Program document by contacting Perennial Advantage Provider Services email at compliance@perenniadvantage.com or call:

- **CO:** 1-844-788-6959 (TTY 711), option #2
- **OH:** 1-844-788-6986 (TTY 711), option #2