SPRING 2024

ULTIMATE HEALTH PLANS

ProviderNews

Preferred DIABETIC
Products and Continuous Glucose Monitors

Health Equity & Race and Ethnicity Data

FLU Season

Participating Provider Billing

Assessment of NEW Medical Technology

Mission Statement
Ultimate Health Plans' mission is to provide all members with the highest quality healthcare with access to highly qualified physicians. We hold ourselves accountable for treating our members with dignity and respect, providing world-class customer service, and recognizing our commitment to the community as a local corporation.

Covering Physicians

A covering physician can bill incident to when providing services for another provider's patients. There is a time limit of 60 days unless first provider has been called to active-duty military service. There shall be a per diem, informal or reciprocal agreement between the providers. When billing claims are to be billed under the primary provider using the correct modifier Q5 or Q6. The primary provider is to keep a record of each service provided by the covering physician and their NPI number available to plan on request. The covering provider is not to submit a claim. Covering Physician requirements does not apply to network participating providers under the same capitation agreement.

Participating Provider Billing

When submitting claims for consideration, please remember to submit claims with your Tax Identification Number (TIN) that was submitted for credentialing. If a claim is received with a tax Id not submitted on your application and credentialed under, your claim will be denied.

How to Request a Coverage Determination (Prior Authorization) for a Medication

A coverage determination, also known as prior authorization, is a determination made by the plan or delegated entity (in our case, OptumRx) regarding a tiering exception, formulary exception, or Utilization Management (UM) criteria. The request can be submitted to OptumRx by the member or the prescriber via online portal, phone, fax, or mail. Drugs not on our formulary can also go through the coverage determination process. (If approved, the member will pay the Tier 3 co-pay). Providers can initiate a coverage determination on behalf of the member by calling the prescriber line for OptumRx at 1-800-711-4555 or electronically by going to https://professionals.optumrx.com/.

CoverMyMeds

CoverMyMeds

Submit an e-PA using the CoverMyMeds provider portal.

covermymeds

Select

Surescripts

Electronic prior authorization

Submit an e-PA using Surescripts prior authorization portal.

surescripts

Select

ULTIMATE HEALTH PLANS

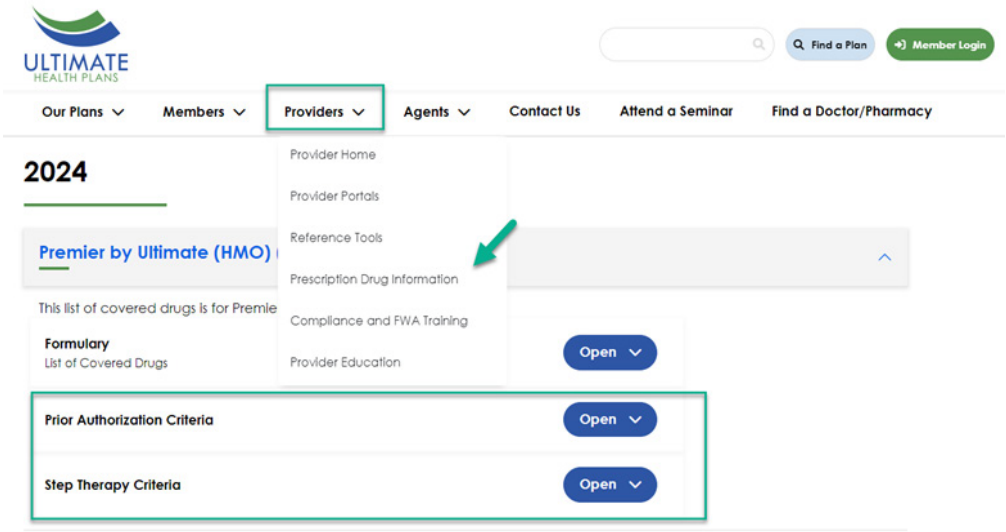
Please remember the CMS required timeframes associated with **standard** and **expedited** Coverage Determination requests. The timeframes apply 7 days a week (including holidays).

- 24 hours are allowed for expedited requests.
- 72 hours are allowed for standard requests.

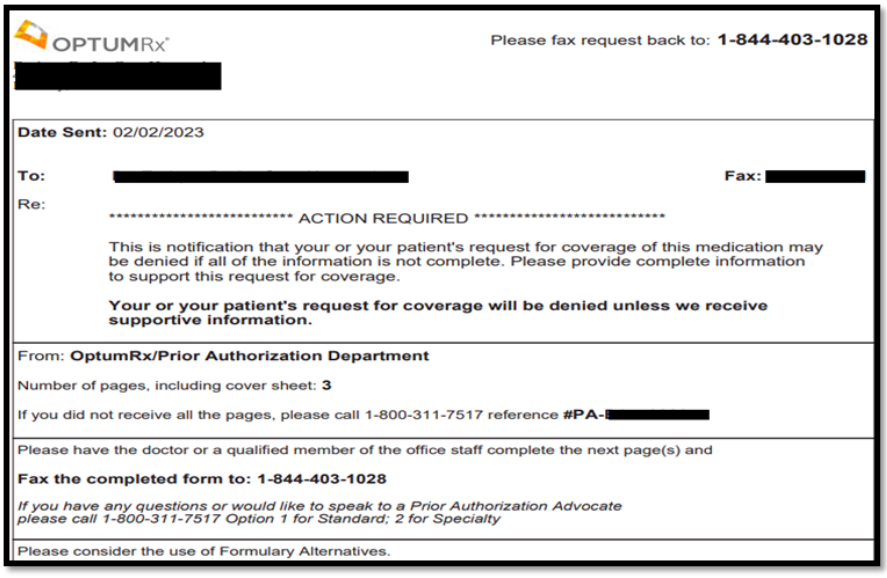
Timeframes measured in hours must be met within the number of hours indicated.

- Example 1: A request for an expedited coverage determination is received on May 1 at 10:30 am. Given the 24-hour timeframe, the plan must make a determination no later than 10:30 am on May 2.
- Example 2: A request for a standard coverage determination is received on May 1 at 10:30 am. Given the 72-hour timeframe, the plan must make a determination no later than 10:30 am on May 4.

Our Prior Authorization and Step Therapy Criteria is posted on our website in the Provider tab.
https://chooseultimate.com/Home/PrescriptionDrugs



OptumRx is the process facilitator of Ultimate Health Plans' coverage determinations. As a provider, you may be asked to provide additional information for the plan (OptumRx) to make a decision on the coverage determination request. Below is an example of what an *additional information* request will look like.



OPTUMRx

Please fax request back to: **1-844-403-1028**

[redacted]

Date Sent: 02/02/2023

To: [redacted] **Fax:** [redacted]

Re:

********** ACTION REQUIRED **********

This is notification that your or your patient's request for coverage of this medication may be denied if all of the information is not complete. Please provide complete information to support this request for coverage.

Your or your patient's request for coverage will be denied unless we receive supportive information.

From: **OptumRx/Prior Authorization Department**

Number of pages, including cover sheet: **3**

If you did not receive all the pages, please call 1-800-311-7517 reference **#PA-**[redacted]

Please have the doctor or a qualified member of the office staff complete the next page(s) and

Fax the completed form to: 1-844-403-1028

If you have any questions or would like to speak to a Prior Authorization Advocate please call 1-800-311-7517 Option 1 for Standard; 2 for Specialty

Please consider the use of Formulary Alternatives.

Provider responsiveness is key, if you receive a request for additional information (RFI), please respond as soon as possible to avoid denial of the request due to lack of information. You can fax 1-844-403-1028 or call 1-800-311-7517.

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Preferred Diabetic Products

Ultimate Health Plans provides coverage for Diabetic Supplies. Traditional Blood Glucose Monitors (BGM), test strips, lancet devices, lancets, and glucose control solutions are covered through the Part B benefit.

Preferred Product:

OneTouch® (Johnson & Johnson) traditional BGM and test strips are the preferred diabetic products.

OneTouch® products can be obtained through your local in-network retail or mail-order pharmacy

Other Options:

Other non-preferred brands of glucose monitors and test strips (including generic products) are available through the plan's in-network Durable Medical Equipment (DME) providers, which can be found in the Provider & Pharmacy Directory or by visiting https://www.chooseultimate.com/Home/FindDoctor.

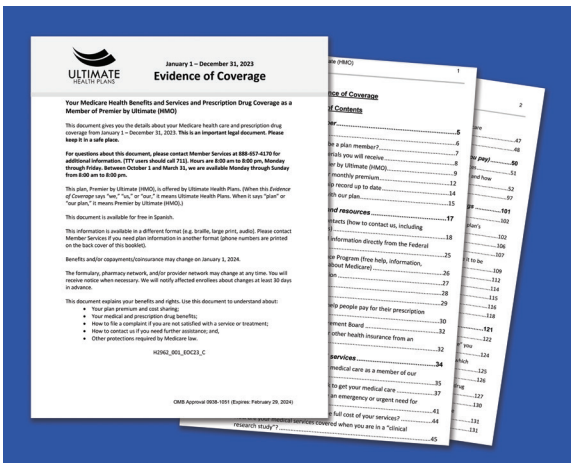
Continuous Glucose Monitors (CGM), i.e., Freestyle Libre, Dexcom, and supplies, are not available at retail pharmacies. However, they are available through the plan's in-network DME providers and require prior authorization and must be submitted to the portal in Calypso Lyte or faxed to Ultimate Health Plans fax # 352-515-5975.

Please note that these requests should not be sent to OptumRx.

Coverage Decisions, Appeals, and Complaints

You can learn about the processes for coverage decisions, appeals, and complaints by reading the following sections of our Evidence of Coverage (EOC) or by reaching out to us. A copy of their EOC is available online at www.ChooseUltimate.com or they can call 1-888-657-4170 to request we mail them a copy.

- Situations in Which You Should Ask Us to Pay Our Share of the Cost of Your Covered Services or Drugs *(EOC Chapter 7, Section 1)*
- How to Make a Complaint *(EOC Chapter 9, Section 10)*
- A Guide to the Basics of Coverage Decisions and Appeals *(EOC Chapter 9, Section 4)*
- Independent Review Entity Step-by-Step: How a Level 2 Appeal is Done *(EOC Chapter 9, Section 5.4)*



Assessment of New Medical Technology

Ultimate Health Plans has a formal process to evaluate and address new developments in technology and new applications of existing technology. We consider including new technology in our benefit plans to keep pace with changes and to ensure our members have equitable access to safe and effective care. To learn more about this formal process, please visit www.ChooseUltimate.com.

Understanding Our Benefits

Knowing the benefits our members receive is important. You can refer to the following sections of the Evidence of Coverage (EOC) to learn about them in detail. A copy of their Evidence of Coverage is available online at www.ChooseUltimate.com or they can call 1-888-657-4170 to request we mail you a copy.

- Services that are Covered for You and How Much you Will Pay *(EOC Chapter 4, Section 2.1)*
- Services that are Not Covered by the Plan *(EOC Chapter 4, Section 3.1)*
- Restrictions on Coverage for Some Drugs *(EOC Chapter 5, Section 4)*

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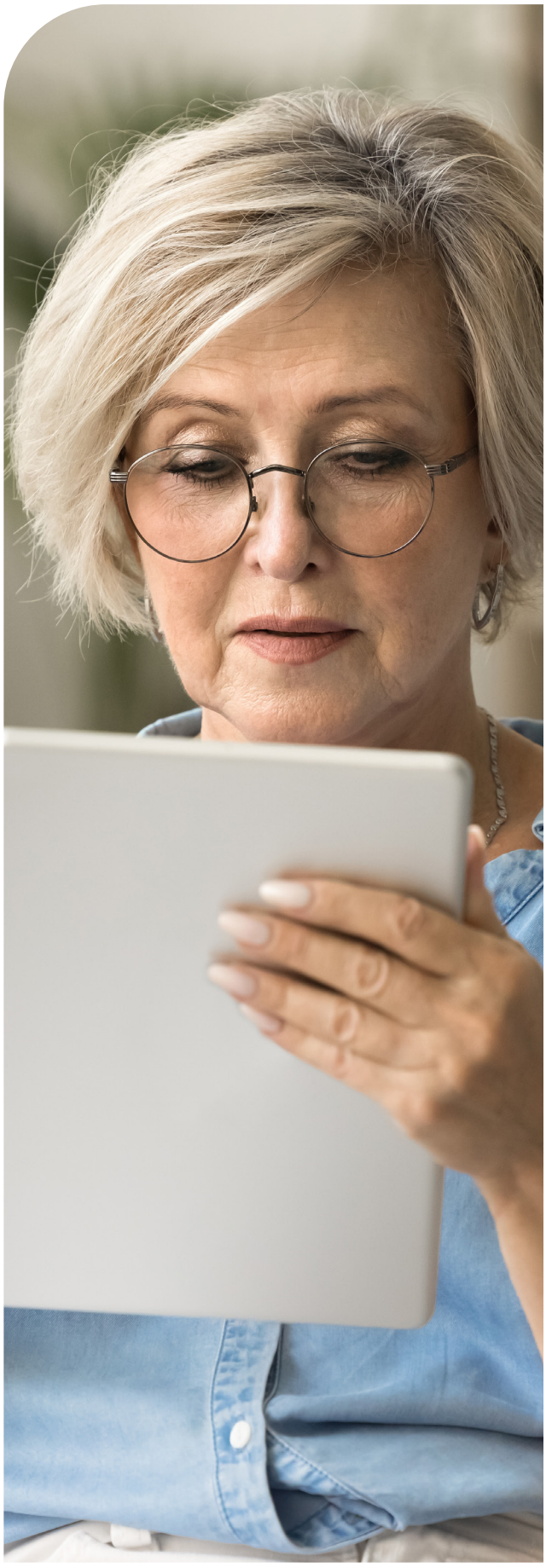
Obtaining Care

Your health is valuable, so it's essential to know how to find in-network providers and obtain the care you need. They can refer to the following sections of their Evidence of Coverage (EOC) on these topics. A copy of their Evidence of Coverage is available online at www.ChooseUltimate.com or they can call 1-888-657-4170 to request we mail them a copy.

- The Provider and Pharmacy Directory: Your Guide to all Providers in the Plan's Network (EOC Chapter 1, Section 3.2)
- Obtaining Primary Care Provider (PCP) Services to Oversee Your Medical Care (EOC Chapter 3, Section 2.1)
- How to Get Care from Specialists and Other Network Providers (EOC Chapter 3, Section 2.3)
- How to Get Care from Out-of-Network Providers (EOC Chapter 3, Section 2.4)
- Getting Care When You Have an Urgent Need for Services – After Hours and Outside the Plan's Service Area (EOC Chapter 3, Section 3.2)
- Getting Care if you have a Medical Emergency (EOC Chapter 3, Section 3.1)



Your Rights and Responsibilities

Ultimate Health Plans honors our member's rights. They have the following rights to help protect themselves:

- We must treat them with fairness, respect, and dignity at all times
- We must ensure that they get timely access to your covered services and drugs
- We must protect the privacy of their personal health information

For a full list of member rights and responsibilities , please visit our website at www.ChooseUltimate.com/Member/RightsAndResponsibilities or call 1-888-657-4170 to request we mail you a copy.

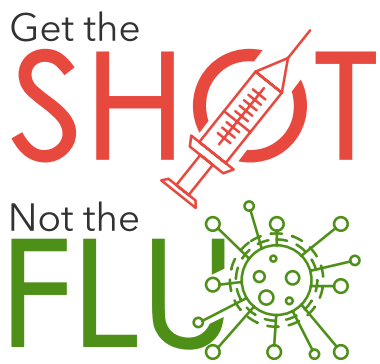
ULTIMATE HEALTH PLANS

Flu Season

Flu season is usually between October and May every year. The Centers for Disease Control and Prevention (CDC) recommends vaccination before the virus starts spreading. Those at high risk include:

- ✓ Adults 65 years of age and older
- ✓ People with chronic diseases
- ✓ People that reside in long-term care facilities
- ✓ Younger children
- ✓ Pregnant women

Members of Ultimate Health Plans have a $0 copay for the flu vaccine. Members can learn more or schedule an appointment by calling or visiting their Primary Care Physician (PCP) or one of our in-network pharmacies. Please visit https://ChooseUltimate.com/Home/FindDoctor on our website to find in-network providers and pharmacies.



You have a $0 Copay.

Advance Directive Rights

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes).

The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

You can complete an advance directive by downloading the form from www.ChooseUltimate.com/Member/DocumentsandForms or call Member Services at 888-657-4170 (TTY 711) to request we mail you a copy. Make sure that your primary care doctor, attorney, and the significant persons in your life know that you have an advance directive and give them a copy. You may also want to keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.

Once you complete the forms, you can mail them to the following address for processing:

Ultimate Health Plans
PO Box 3459
Spring Hill, FL 34611

Medicare law gives you the right to file a complaint with the Agency for Health Care Administration (AHCA) if you are dissatisfied with our process for handling Advance Directives by calling 1-888-419-3456 (TTY 800-955-8771).

If they change your advance directives, make sure your health care provider, attorney, and the significant persons in your life have the latest copy.

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Special Needs Plans (SNP)

At Ultimate Health Plans, we are proud to offer several Special Needs Plans to our members, your patients. Special Needs Plans are a type of Medicare Advantage Plan that provides coordinated care to members with specific illnesses or chronic conditions. We offer five SNP plans in the counties we service on the East and West Coast and Central Florida.

Advantage Care by Ultimate (HMO C-SNP)	Advantage Plus by Ultimate (HMO D-SNP)
• Cardiovascular Disorder • Chronic Heart Failure • Chronic Lung Disorder • Diabetes Mellitus	• Dual Eligible (Member qualifies if eligible for both Medicare and Medicaid)

Some Benefits Available to SNP Members Include:

- Case and Disease Management
- Social Services
- Transition of Care
- Benefit for Over-the-Counter Products
- Food Benefit
- Telehealth Services
- Transportation Services
- Routine Dental, Vision, and Hearing Benefits
- SilverSneakers Program (Gym Membership)
- Meal Benefit

If you feel a patient meets the criteria and isn't enrolled in a Special Needs Plan, please reach out to your Provider Network Representative or the Provider Service Department at 1-888-657-4171 to better assist you in getting your patient, our member, the care they need.

ULTIMATE HEALTH PLANS

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TRANSITION OF CARE TIPS FOR PROVIDERS

NCQA assesses key points of transition for Medicare Beneficiaries after discharge from an inpatient facility. Four rates are reported:

1. Notification of Inpatient Admission
   Documentation in the medical record of receipt of notification of inpatient admission.
2. Receipt of Discharge Information
   Documentation in the medical record of receipt of discharge information.
3. Patient Engagement After Inpatient Discharge
   (e.g., office visits, visits to the home, telehealth) provided within 30 days of discharge.
4. Medications Reconciliation Post-Discharge
   Medication reconciliation on the date of discharge through 30 days after discharge.

Upon Patient Admission, What Can a Provider Do?

1. Communicate between hospitalist/staff and PCP for patient's ongoing care (e.g., phone call, email, fax).
2. Communicate a complete list of current medications the patient is taking at home, including over-the-counter medications, vitamins, herbals, and nutritional supplements, with hospitalists.
3. Communicate a list of the patient's medication allergies and drug intolerances.
4. Primary Care Provider (MD, DO, Mid-level) should make outreach to the patient and/or patient's family/next of kin to provide support and foster the relationship.

Upon Patient Discharge Home, What Can a Provider Do?

1. Make outreach to the patient within 72 hours of discharge to assess the patient's need for help with ancillary providers such as Home Health, DME, or any medication questions.
2. Emphasize the importance of a follow-up appointment, ideally within seven (7) days of discharge. At the time of appointment scheduling, you can request the patient to bring in hospital records if they are able to.
3. Instruct the patient to bring all medications they take at home and the discharge instructions from the hospital to the follow-up appointment.
4. Communicate with the facility with a request to fax/email the discharge summary (including medication list) prior to the appointment or obtain it through the hospital/facility EMR/EHR.
5. Coordinate a review and reconciliation of the patient's medications from the discharge summary.
6. Help the patient coordinate any follow-up visits with specialists.
7. Educate the patient or their caregiver at hospital follow-up visits and provide discharge instructions that are simple and easy to read. Include a complete list of medications, including medication names, dosages, frequency, over-the-counter (OTC) medications, and herbal or supplemental to ensure comprehension and avoid adverse events.

ULTIMATE HEALTH PLANS

Health Equity & Race and Ethnicity Data

As Ultimate Health Plans grows, it is important that we begin discussing the very important topic of Health Equity & Race and Ethnicity Data collection and analysis. It has been widely documented that there is a prevalence of racial and ethnic health disparities in the United States. We, here at Ultimate Health Plans, want to ensure we are doing everything we can to break any barriers for our members to receive the care they deserve.

NCQA has implemented for the measurement year 2024, race and ethnicity stratification for seven HEDIS (Healthcare Effectiveness Data and Information Set) measures, specific to Medicare:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Glycemic Status Assessment for Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Eye Exam for Patients with Diabetes
- Adult Immunization Status

The stratification will be implemented by:

- stratifying race and ethnicity separately
- include options for the member to decline answering and not provide their race or ethnicity
- allow self-reported member data and indirect imputed data
- use existing HEDIS audit and hybrid sampling guidelines

By gathering this type of data, will allow us to see any disparities in specific populations that we can address. It will also allow us to see where our populations are thriving and the best practices we have put in place that we can build upon.

By identifying the disparities, we can also make attempts to fix the health inequities that occur, as they not only affect lives but affect finances and can create an economic burden to the members we serve.

Thank you for partnering with us to help your patients, our members, to give them the best possible care.

NCQA

NONDISCRIMINATION, ACCESSIBILITY, AND LANGUAGE ASSISTANCE

Ultimate Health Plans complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. Ultimate Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages

If you need these services, contact Ultimate Health Plans Member Services. If you believe that Ultimate Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities, you can file a grievance with the Ultimate Health Plans Grievance Department. Address: P.O. Box 6560, Spring Hill, FL 34611. Phone: 1-888-657-4170 (TTY users dial 711). Fax: 1-800-313-2798. Email: GrievanceAndAppeals@ulthp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, an Ultimate Health Plans Grievance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-657-4170 (TTY: 711).
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-657-4170 (TTY: 711).
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-657-4170 (TTY: 711).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-657-4170 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-657-4170 (TTY: 711）。
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-657-4170 (ATS: 711).
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-657-4170 (TTY: 711).
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-657-4170 (телетайп: 711).
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-657-4170 (رقم هاتف الصم والبكم: 117).
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-657-4170 (TTY: 711).
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-657-4170 (TTY: 711).
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-657-4170 (TTY: 711)번으로 전화해주십시오.
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-657-4170 (TTY: 711).
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-657-4170 (TTY: 711).
เรียน: ถาคุณพดภาษาไทยคุณสามารถใชบริการชวยเหลือทางภาษาไดฟรี โทร 1-888-657-4170 (TTY: 711)

Ultimate Health Plans' Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-657-4170 (TTY: 711). Someone who speaks English or the needed language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-657-4170 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-657-4170 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-657-4170 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-657-4170 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-657-4170 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-657-4170 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-657-4170 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-657-4170 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-657-4170 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-657-4170 (برقياً: 117). سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

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