ULTIMATE HEALTH PLANS
Good health is where you live.

2023 Provider Manual

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Purpose of the Provider Manual

Ultimate Health Plans' "Provider Manual" was developed for use by contracted Providers and their staff. It is included by reference in the contractual agreement (the "Agreement") between Ultimate Health Plans and the Provider, and it is intended to establish guidelines to facilitate compliance with Ultimate Health Plans' established policies and procedures.

This provider manual contains general information that should be utilized by Providers and their staff when caring for Ultimate Members. Nothing in this manual is intended to prohibit or restrict the Provider from advising a member regarding:

- The Member's health status, medical care, or receiving sufficient information when considering treatment options (such as alternative treatments which may be self- administered) regardless of benefit coverage limitations.
- The risks, benefits and consequences of treatment or non-treatment
- The opportunity for the Member to refuse treatment and express preferences about future treatment decisions.

To provide you with the most current information, the provider manual will be revised periodically at the sole discretion of Ultimate Health Plans. The Provider will have access to the most updated version of the provider manual via the internet through the Ultimate website at www.chooseultimate.com. A hard copy will also be available by contacting the Provider Relations Department.

A designated Provider Relations Representative will be available to you and your office staff during regular business hours. We encourage our Providers to contact their Representative for updates and support, or with any questions, concerns, and suggestions that they may have. We will do our very best to work together and assist you and your staff in providing quality care to our members.

Participating Providers

Ultimate has established relationships with Providers which include, but are not limited to, Primary Care Physicians, specialty care providers, ancillaries, hospitals, pharmacies, and laboratories. To receive full benefit coverage, Members must generally use a participating Provider, except in limited circumstance, such as an emergency, in or out of the service area, or when specifically authorized by Ultimate.

Benefit Plans

Ultimate will provide coverage for health care services to Members enrolled in our Medicare Advantage programs. All contracted Providers participate in all Plans. Detailed information about our benefit plans may be found in the Ultimate Health Plans Summary of Benefits and Evidence of Coverage documents, which may be downloaded from the Ultimate web site at www.chooseultimate.com.

Service Areas

2023 Counties: Citrus, Hernando, Hillsborough, Indian River, Lake, Manatee, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Saint Lucie, Sarasota, Seminole, and Sumter

Ultimate Health Plans offers benefit plans through its participating network of Providers in approved counties throughout the state of Florida. A Member residing in an area where Ultimate is approved for servicing may access health care services through a participating network Provider.

Standards and Accreditation

Ultimate will comply with all state and federal regulations pertaining to Health Plan administration. Ultimate is accredited by the National Committee for Quality Assurance, NCQA.

Forms & Resources

All forms referenced in the “Provider Manual” are available to you and your staff. Please refer to the “Forms & Resources” Section of this Provider Manual. All forms are also available for download from the Ultimate web site at www.chooseultimate.com.

RESPONSIBILITIES OF ULTIMATE HEALTH PLANS Section 2

The following section addresses the responsibilities of Ultimate Health Plans:

1. Assist participating Providers in meeting the expectations of Ultimate.
2. Maintain a record of eligibility for all enrolled Members. Members will receive an identification card from Ultimate, which must be presented at time-of-service.
3. Process Member enrollment and disenrollment applications, as appropriate.
4. Educate and encourage Members to participate and make use of preventive healthcare services.
5. Keep participating Providers informed of any changes set forth by regulatory and/or accrediting entities governing Ultimate such as, but not limited to, Centers for Medicare and Medicaid Services (CMS), the Office of Insurance Regulation (OIR), the Agency for Health Care Administration (AHCA), and the National Committee for Quality Assurance, (NCQA).
6. Provide Member Service Representatives to support and handle any concerns and/or issues that Members or Providers may encounter.
7. Provide support through Provider Relations Department to handle issues regarding the Agreement and/or any concerns.
8. Provide and maintain a network of participating Providers composed of primary care, specialist, ancillary and hospital facilities to coordinate health care services for Members.
9. Assist and support Provider in the coordination of referrals and authorizations for health care services by another Provider.
10. Maintain and monitor a panel of Primary Care Providers for which the Member may select a physician as their Primary Care Provider (PCP).
11. Perform periodic site visits to Primary Care Provider offices and/or other Providers, as deemed necessary, to ensure compliance with Ultimate's established procedures, access information, and response to inquiries concerning issues which may relate to quality of care.
12. Ensure that Ultimate's utilization and practice guidelines are communicated to Providers. Ultimate will measure Provider's adherence to such on a regular basis. Utilization management criteria with sources and the most current practice guidelines with website addresses may be found on the Ultimate website: www.chooseultimate.com
13. Provide training and support to Provider regarding Ultimate's clinical guidelines, quality improvement programs, medical management, and health promotion activities.
14. Ensure that Ultimate and its participating Providers conduct business in a manner that safeguards patient/Member information in accordance with HIPAA privacy regulations.
15. Investigate suspected fraud, waste and abuse as required by state and federal agencies, such as, but not limited to, the Centers for Medicare and Medicaid Services (CMS), the Office of Insurance Regulation (OIR) and the Agency for Health Care Administration (AHCA).

The following section addresses the responsibilities as well as the regulatory and accreditation requirements of the Primary Care Provider.

Role of the Primary Care Provider (PCP)

The Provider Manual is a resource tool that assists in providing information. Every effort has been made to keep the policies and procedures as standardized as possible for Providers and their office staff.

Guidelines for Patient Care

Providers are expected to adhere to the following patient care guidelines, and will:

- Provide or coordinate health care services to Members which meet recognized professional standards and those standards provided by Ultimate in the areas of operations, clinical practice guidelines, Member satisfaction, and fiscal responsibility.
- Understand that the information provided by Ultimate in either the “Provider Agreement” or the “Provider Manual” is not intended to interfere with, or hinder communications between, Provider and Member regarding a patient’s medical condition or available treatment options, including medication treatment options, regardless of benefit structure.
- Preserve the Member’s dignity; fully disclose treatment options to the Member and allow the Member to be involved in the process of treatment planning.
- Discuss all aspects of a member’s health with them and understand the Member’s benefits under their respective benefit plan to ensure conversations about treatment options that are comprehensive.
- Educate Members on follow-up care and provide training when necessary.
- Provide services in a culturally competent manner, i.e., remove all language barriers to those patients with limited English proficiency or reading skills, as well as those with diverse cultural and ethnic backgrounds
- Comply, as required under federal law, with the HIPAA guidelines and “Privacy Rules.” Notice of compliance with privacy practices must be posted in the Provider’s office in an area where Members may view it
- Maintain the quality of medical record keeping and adhere to all Ultimate’s policies governing the content of medical records. Treat all Member records and information confidentially and do not release such information without the express written consent of the Member, except as indicated herein, or as allowed or needed for compliance with state and federal law.
- Transfer copies of medical records within five (5) business days or sooner if clinically necessary, to other Providers upon request and at no charge to Ultimate, the Member or to the requesting party, unless otherwise agreed upon.
- Inform Ultimate in writing within twenty-four (24) hours of a suspension, limitation or revocation of any of his/her licenses, certifications or other legal credentials authorizing him/her to practice in the state of Florida.
- Inform Ultimate immediately of changes in tax identification numbers, telephone numbers, addresses, status at participating hospital(s), loss of liability insurance and any other change which would affect his/her status with Ultimate.
- Coordinate, monitor and supervise the delivery of primary care services to ensure continuity of care to the Members. Submit authorization request information to the Health Services Department within the timeframes set forth in this Provider Manual for authorizations, review authorization requests of Specialty Providers as required, and provide information to the Member upon request.
- Work cooperatively with other Providers to uphold the standard of ethics of the health care profession in which the Provider practices.
- Refer Members to participating Providers. (When not available, prior authorization for out- of-network Providers must be approved by Ultimate, unless it’s a case of emergency).
- Admit Members to participating hospitals, SNFs, and other inpatient care facilities, except in case of an

emergency. Provider will work with the Health Services Department and the Case Manager to coordinate Member's care in case of a possible acute hospital stay.

- Ensure that, when medically necessary, services are available 24 hours a day, 7 days a week, including the capability to provide directions to Members on how to obtain after- hours care. This includes the requirement for Primary Care Providers to have appropriate backup for absences.
- Have clearly defined and communicated, by prominently posting in their offices, their hours of operation that do not discriminate against a specific type of Member.
- Arrange for the provision of covered services when the Provider office is not open. The on- call and after-hours coverage must be arranged with a participating and credentialed Ultimate Provider.
- Not discriminate between a Member and other patients in the practice based upon their health status, race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or genomic information.
- Comply with Ultimate standards for timely access to care and services:
    - Urgent Care - within one (1) day
    - Sick Patient Care - within one (1) week
    - Well Care/Routine and Preventive Care - within thirty (30) days.
- Assess appropriate care for Member's medical condition and refer life-threatening conditions to the nearest emergency room.
- Monitor in-office wait time, which should not exceed more than thirty (30) minutes from check-in time to the time the Provider sees the Member.
- Not bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from, or have any recourse against Member, other than the co-payments or fees for non- covered services furnished on a "fee-for-service" basis.
- Not bill the Member for missed appointments; the Provider should document the missed appointment in Member's medical records and, if necessary, request assistance from the Member Service Department with the follow up.
- Maintain a ratio of Members to full-time physicians as follows:
    - One physician FTE per 1,000 Medicare Members
- The Health Plan may increase the ratio by 750 Members for every full-time Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) affiliated with the PCP.
- Direct the Member to contact the Member Service Department for the availability of non- emergency medical transportation service and ensure Members are aware of public transportation where available.
- Allow access to Ultimate or its designee to examine the Provider's office(s), books, records, and operations of any Member-related services which were provided, and be responsible for the direct training and supervision of his/her office staff. Duties of the medical assistant will be strictly limited to those identified in the Florida Statutes.
- Train the office staff on the proper use of safety, emergency, and fire-extinguishing equipment.
- Have emergency medications and/or equipment on hand maintained as required (i.e., EpiPen®, Artificial Manual Breathing Units/Ambu bags, crash cart, etc.) in case a medical emergency occurs during hours of operation.
- Maintain all facilities with handicapped accessibility, adequate space, supplies, proper sanitation, and fire safety procedures in the day-to-day operations.
- Keep an environmentally safe office with equipment in appropriate working order to comply with city, state, and federal regulations, concerning safety and public hygiene.
- Ensure that universal precautions and O.S.H.A. guidelines are followed by utilizing disposable equipment and supplies or proper sterilization methods of instruments used to perform procedures.
- Apply for/or maintain a "Clinical Laboratory Improvements" (CLIA) certificate, if applicable by law.

Disclosure of Information

From time-to-time, Members may inquire (either verbally or in writing) regarding the operational and financial nature of Ultimate. In accordance with federal and state disclosure requirements, Ultimate is obliged and will provide that information to the Member upon request. Provider will refer Member to the Member Advocate Team in response to such inquiries.

Living Will and Advance Directives

Members have the right to control decisions relating to their medical care. This includes the right to refuse treatment and/or medical procedures. The law provides that each Member (age eighteen [18] years or older and of sound mind) should receive information concerning this provision and have the opportunity to sign an Advance Directive Acknowledgement form. This allows Members to make their decisions known in advance and to designate another person to make decisions on their behalf should they become mentally or physically unable to do so. Members also have the right to file a complaint if they are dissatisfied with Ultimate's process for handling Advance Directives and participating Providers shall comply with 765.1105, F.S. state requirements.

Provider's offices should discuss the importance of Advance Directives with their Members. The completed forms should be documented and filed in a prominent part of the Member's medical record, as well as he documentation on whether Member has executed an Advance Directive. The Provider shall not, as a condition of treatment, require the Member to execute or waive an advance directive. The Health Care Advance Directives/Living Will form can be found in the "Forms & Resources" Section of this Provider Manual.

Copies of Advance Directives forms and instructions may also be found on the Ultimate website: www.chooseultimate.com

Ultimate strives to focus on providing its Members with coverage for the most efficient delivery of health care services. The following are the duties of the Primary Care Provider and their office staff. Ultimate will monitor and assist Provider/staff in complying with the following processes:

Assignment of the Primary Care Provider (PCP)

At the time of enrollment, a Member may select and/or may be assigned to a Primary Care Provider (PCP) from the Ultimate Provider Network. Members may change their PCP for any reason, at any time. Generally, the change to a new PCP will take place on the first day of the month following the Member's request. If the change is made within the first 10 days of the month, the new PCP assignment may take effect retroactively to the first day of the month if the Member requests it.

Membership Listing, Eligibility and Verification

A current Membership listing (panel report) will be provided to the offices of the Primary Care Provider by the 10th of each month for eligibility verification purposes. The most current Membership eligibility information is accessible through our Provider Portals. Providers must register and agree to the terms and conditions of the portals in order to obtain credentials to access their information. Portal Access Information and Registration is available at https://www.chooseultimate.com/Provider/Portals.

Prior to providing care to a Member, Participating Providers must verify the Member's eligibility status at time of service. This can be accomplished either by calling the Provider Service Department at 1-888-657-4171 or online by accessing Ultimate's Provider Portal.

Primary Care Provider Panel/Membership Changes

Primary Care Providers will need to communicate any changes regarding panel status to Ultimate Health Plans in writing no later than 60 days in advance through providers contracted IPA/MSO, unless otherwise agreed. Members in which are assigned to providers panel within the allotted time period, will remain on providers panel/membership listing.

Member Identification Cards

At the time of accepted enrollment, each Member will be issued an ID card with the Member's assigned PCP. The identification card assists the Provider verifying coverage and benefits. Member must present ID card at each appointment, emergency visit or inpatient stay.

Please note that the processing of enrollment applications can impact when Members receive their Member ID Cards in the mail, as such provision of service should not be conditioned solely on the presentation of an ID card, nor does it guarantee eligibility or payment of benefits because a Member's enrollment status can change.

Providers should verify Member eligibility at time of service on the Portal or by Calling Provider Service at 1-888-657-4171. Examples of Ultimate Member ID Cards can be found in the "Forms & Resources" Section of this Provider Manual.

Member Services Department

The Member Services department is available to assist Members Monday through Sunday from 8 a.m. to 8 p.m. Members should dial 1-888-657-4170. TTY users should dial 711.

Co-Payments

All co-payments should be collected in accordance with the information on the Membership cards or by calling the Member Services Department.

Appointment Scheduling

Along with Ultimate's policies and procedures, Providers must adhere to the following criteria to remain in compliance with state and federal guidelines regarding the "Emergency, Urgent and Routine Appointment" availability standards:

Appointment Type	Standard for Appointment Time Frame
Emergency Care	Immediate medical attention. If not immediately available, call 911.
Urgent Care	Medical attention within 24 hours of member notification.
Non-Urgent Sick Care	Medical attention within 1 week of member notification.
Routine Primary Care	Visit within 4 weeks of member request.
After–Hours Access Standards 24-Hour Accessibility	All network practitioners must be available, either directly or through coverage arrangements 24 hours a day, 7 days a week, 365 days a year. After-hours coverage must be accessible using the medical office's daytime telephone number, through an answering service, call forwarding, or PCP call coverage. The PCP or covering medical professional must return the call within thirty (30) minutes of the initial contact.

If a delay in a scheduled appointment is unavoidable, the Provider must communicate with the Member about the delay and provide alternatives.

Missed Appointments

Providers should have a process in place for Member's missed appointments. The Provider Relations Department is available to assist the Provider with this process, if needed. Scheduled appointments missed without prior cancellation should be documented by the Provider in the Member's medical record. However, the Provider will not charge Member for missed appointments.

Coordination of Care

Providers will coordinate health services for their assigned Member. Provider will work with the Health Services Department and collaborate with Case Managers and/or Ultimate's Medical Director for services requiring prior authorization.

To maintain continuity of care, Provider shall, always, stay informed of his/her patient's care in an acute care facility/hospital, nursing home and at home, even when there is a hospitalist and/or specialist managing the Member's care.

Provider Termination Request

If a Provider wishes to be terminated from the Ultimate Network, Provider must notify Ultimate in writing no less than 60 days prior to the date of termination, unless otherwise indicated in Provider's contractual agreement. Primary Care Providers must route their termination request through IPA/MSO partner for processing.

Ultimate is responsible to communicate termination of providers to Ultimate members by written communication no less than 30 days prior to termination effective date.

Continuity of Care for Terminated Providers

Members undergoing active treatment with Terminated Provider for a chronic or acute condition may continue treatment through its completion or no more than 6 months from the date of provider termination from Ultimate Network, whichever is earlier. Member must call Ultimate Member Advocate Team at 1-800-219-7486 (TTY dial 711) between the hours of 8:00 AM and 5:00 PM to ensure the continuity of care.

Claims/Encounters
Claim and/or encounter forms must be submitted to Ultimate within a timely manner. Please refer to the Claims Section of this Provider Manual for Ultimate policies and procedures regarding submission and claims processes.

Medical Record Retention
Provider will comply with CMS Regulations by maintaining medical records for a minimum of ten years.

After-Hours Access
All Primary Care Providers are required to provide twenty-four (24) hour-a-day, seven (7) days per week coverage, with the capability to provide directions to Members on how to obtain after- hours care. It is not acceptable to have an outgoing message directing Members to call 911 without additional options for after-hours access. Normal hours of operation should be clearly defined and communicated to Members.

Covering Physicians
In the event the Provider is temporarily unavailable to provide healthcare services to Members, except in the case of an emergency, Provider must make arrangements with a participating and credentialed Provider to provide services on their behalf. In non-emergency cases, should the Provider wish to have services provided to Members by a covering physician who is not participating with Ultimate, the Provider should contact the Provider Relations Department for assistance. The non-participating covering physician will have to undergo a preliminary credentialing process. He/she will be required to accept the Provider's negotiated rate and agree not to balance bill Plan Members by signing an interim agreement.

Provider Billing and Address Changes
Provider is required to notify Ultimate about changes to any of the following:
- NPI
- Group name or Affiliations
- Practice Address
- Billing/Remit (W-9 Required)
- Telephone and/or fax numbers

PCP and Member's Initial Appointment
The Primary Care Provider or Physician Extender is required to contact each new Member within ninety (90) days of enrollment (effective date), to perform an initial health assessment. At the time of the initial visit, a "Release of Medical Records" form should be signed by the Member in order to request medical records from prior physicians.

The PCP will use the previous medical records and the health risk assessment to identify Members who have not received age-appropriate preventive health screenings. Health screenings for adults should meet medical community standards, such as those established by the Centers for Disease Control and the US Preventive Services Task Force. When external regulating agencies impose more stringent standards, the Provider will be required to comply with those standards.

Member Disenrollment
There are very specific instances when a Member may be involuntarily disenrolled, as indicated in the Member's benefit plan. A Member may not be disenrolled for pre-existing medical conditions or change in health status.

If a Member (or Member's legal guardian) requests to be disenrolled, please refer the Member to our Member Advocate team. Our Member Advocate Team is here to bridge communications between Ultimate Health Plans Members, Providers, and suppliers. Our Member Advocates are at both below Ultimate locations in Hernando County:

Ultimate Health Plans, Inc.
1244 Mariner Boulevard
Spring Hill, FL 34609
(352) 835-7151

Ultimate Health Plans, Inc.
2713 Forest Road
Spring Hill, FL 34606
(352) 835-7168

The Provider must continue to provide medical care for the Member, until such time he/she receives verification that the Member disenrollment is effective and, that the Member has been transferred to a new PCP.

If the disenrollment is approved, the Member must receive a thirty (30) day notice to allow him/her adequate time to select another Provider or make other arrangements for health care services. Please note, a Member (or Member's legal guardian) will have the right to file a formal grievance if they do not agree with the disenrollment from their existing PCP.

Member Transfer Requests

A Member or Member's legal guardian may request to change their Primary Care Provider (PCP) by either sending in a written request and/or contacting the Member Services Department telephonically. The change will be effective on the first day of the following month. Special circumstances may warrant a mid-month transfer.

A Provider or their staff may not, in any way, coerce or encourage a Member to transfer. Provider should make every reasonable effort to establish a satisfactory Provider/Member relationship.

If a Provider has no other recourse but to transfer a Member to another PCP, he/she must complete the "Member Transfer Request Form", and submit the form, along with the supporting documentation to the Provider Relations Department for review. A copy of the form is available on the Ultimate website, www.chooseultimate.com. The Provider will be notified of the decision within 7-10 business days.

If the request is approved, the Provider must notify the Member of the dismissal via a written notification letter. The member transfer will become effective on the 1st of the following month. Members (or Member's legal guardian) will have the right to file a formal grievance if they do not agree with the transfer.

If the request is denied or until the approved member transfer becomes effective, the Provider must continue to provide medical care for the Member until such time he/she receives confirmation or documentation, such as a new panel report, to confirm that the Member is no longer assigned under the Provider's care.

Cost Reallocation

Members are able to change their Primary Care Physician (PCP) at any time. This change can occasionally result in financial avoidance for the original IPA and adverse financial risk for the new IPA. If the new IPA feels that the member was transferred for financial reasons versus clinical needs, the new IPA may request review for a possible cost reallocation.

Ultimate Health Plans (Ultimate) has established a process that will ensure appropriate distribution of costs when unusual costs are incurred following a Member transfer from one participating IPA to another participating IPA. This process is called "Cost Reallocation". To obtain a current copy of the Cost Reallocation Policy, please contact Provider Relations.

Out-of-Area Member Care Needs

In some circumstances, a Member may be receiving care out of the service area. In these cases, a redirection of care may be considered medically necessary and/or acceptable by Ultimate and the out-of-network attending physician. Providers may be requested to assist the Ultimate Member Advocate in arranging for the transfer-of-care for an Ultimate Member.

Hearing Impaired/Interpreter and Sign Language Services

By law, hearing impaired, interpreter and sign language services must be made available to Members. Providers should coordinate these services for their Members; Ultimate Member Services Department and Member Advocate Team are able to assist, as needed.

Community Outreach and Marketing

In general, Providers should act in their capacity as a participating Provider of the Ultimate network. All marketing materials describing or mentioning Ultimate, in any way, must first obtain the prior written approval of Ultimate. These materials must adhere to the guidelines and approval of Ultimate, CMS and AHCA, as appropriate.

To the extent that a provider can assist a beneficiary in an objective assessment of his/her needs and potential options to meet those needs, they may do so. Providers may engage in discussions with beneficiaries should a beneficiary seek advice. However, providers MUST remain neutral when assisting with enrollment decisions, the following identifies what a provider may and may not do:

Provider Do's and Don'ts

A Provider MAY**:**

- Provide the names of Plans/Part D Sponsors with which they contract and/or participate (must include all plans with which Provider participates)
- Provide information and assistance in applying for the LIS.
- Make available and/or distribute plan marketing materials.
- Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at http://www.medicare.gov/ or 1-800-MEDICARE.
- Share information with patients from CMS' website, including the "Medicare and You" Handbook or "Medicare Options Compare" (from http://www.medicare.gov), or other documents that were written by or previously approved by CMS.

A Provider MUST NOT**:**

- Offer scope of appointment forms or Accept Medicare enrollment applications.
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Ultimate Health Plans.
- Offer anything of value to induce plan enrollees to select them as their provider.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distribute materials/applications within an exam room setting.

CMS permits Providers to announce new or continuing affiliations for specific plans through general advertising, (e.g., radio, television, websites). Ultimate permits contracted providers to make new affiliation announcements within the first 30 days of the new contract agreement. Providers may announce to patients once, through direct mail, e-mail, or phone, a new affiliation that only names Ultimate. Providers may continue to distribute written materials only if they include a list of all plans with which the Provider contracts in additional direct mail and\or email communications.

Any affiliation communication materials that describe plans in any way, (e.g., benefits, formularies), must be approved by CMS and must include the appropriate disclaimers. Materials that indicate the Provider has an affiliation with certain plans and that only list plan names and/or contact information do not require CMS approval.

Providers should contact the Marketing Department to discuss and/or coordinate permissible Provider marketing activities.

Non-Interference with Advice to Health Plan Members

Nothing in this Provider Manual is intended to prohibit or restrict a Provider from advising or advocating on behalf of an Ultimate Member. Provider may freely communicate about (1) the Health Plan Member's health status, medical care, or treatment options (including medication treatment options or alternative treatments that may be self-administered), regardless of benefit coverage limitations, including providing sufficient information to the Health Plan Member to provide an opportunity to decide among all relevant treatment options; (2) the risks, benefits and consequences of treatment or non-treatment; and (3) the opportunity for the Health Plan Member to refuse treatment and express preferences about future treatment decisions. Provider must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. Provider must assure that individuals with disabilities are furnished with effective communications in making decisions regarding treatment options.

Ultimate Health Plans' Commitment to Quality Care

Ultimate assures Providers and Practitioners that all decisions about how we cover Members' health care are based on appropriateness of care and service. We NEVER compensate doctors or anyone else for making decisions that could result in denying care to our Members. We do not make decisions about hiring, promoting or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff member supports, or tends to support, denial of benefits. Denials are based on medical necessity, benefit coverage or contract provisions. We do not provide incentives to any individual or entity to deny, limit, or discontinue Medically Necessary services to any Member. Ultimate Health Plans works to prevent inappropriate decision-making by regularly monitoring all medical claims and requests for care. We are committed to providing our Members with superior access to quality care.

Patient's Rights and Responsibilities

Florida law requires that health care Providers recognize patient rights while providing medical care and that Member's respect a health care Provider's right to expect certain behavior on the part of their patients. Regulatory requirements state that a copy of the Patient Bill of Rights must be displayed in a prominent location in the Provider's practice locations for Member information purposes. A summary of Florida's Patient's Bill of Rights and Responsibilities can be found on the Ultimate Health Plans website, www.chooseultimate.com. You may request a copy of the full text of this law from your Provider Relations Department.

A copy of Ultimate Health Plans' Rights and Responsibilities statement may be downloaded from the Ultimate website: www.chooseultimate.com.

Consumer Assistance Notice

Members have the right at any time to submit a complaint or grievance to their Plan or to a regulatory agency. The Consumer Assistance Notice assists Members by listing the contact information to submit a compliant or grievance, therefore a Consumer Assistance Notice should be posted in a prominent location in the Provider's practice locations, viewable for Members.

If an Ultimate Member has concerns or complaints, they are encouraged to contact our Grievance Department at 1-888- 657-4170 for assistance.

For your convenience, a copy of the Consumer Assistance Notice can be found on the Ultimate Health Plans website, www.chooseultimate.com.

Credentialing

Ultimate is responsible for validating and assessing the qualifications of network health care Providers and confirming their eligibility to participate in state and federal programs. Policies and procedures have been established to require a Provider requesting participation in the Ultimate network to undergo a credentialing process. All Providers must meet the credentialing criteria and be approved by the Credentialing Committee in order to participate with Ultimate.

A Provider must complete and submit either an Ultimate credentialing application or Council for Affordable and Quality Healthcare (CAQH) application. If you are a provider who is not yet participating in CAQH and would like to, Ultimate can request a CAQH number on your behalf to simplify the credentialing process. To be added to the CAQH database, the "CAQH Request for New Provider" form needs to be completed and returned to the fax number listed. Once the CAQH ID number is generated, the form will be emailed or faxed back to you to gain access to the CAQH database and begin the process. The information provided to Ultimate is verified from primary or secondary sources.
All Providers must sign the "Attestation and Disclosure Statement," in addition to the "Authorization and Release."

Provider's credentials are submitted to the Credentialing Committee who will either approve or deny the Provider's request for participation. Providers will be notified of the outcome of their request electronically by fax and/or email format. However, if a Provider is denied participation in the network, then the Provider will be notified of the determination by mail and will have thirty (30) days to appeal the decision of the committee by requesting reconsideration.

All Providers providing health care services to Ultimate Members must be credentialed, qualified, and practice within their own specialty. In the event a Provider joins a practice which already participates with Ultimate, then the Provider must notify Ultimate in advance to complete the required credentialing process.

Providers cannot see Members until the credentialing process is completed and he/she is approved for participation. If a non-participating Provider does provide services to a Member, those services will not be considered a covered service and will not be reimbursed to the Provider as a participating Provider. Ultimate does not contract with those who are identified with active exclusions by the Office of the Inspector General (OIG) via the List of Excluded Individual/Entities (LEIE), the System for Award Management (SAM), or providers who have opted out of Medicare. Members are never to be held responsible for those services which are not covered due to this circumstance, and the Provider will not bill Members.

Re-Credentialing

All Providers must undergo re-credentialing at least every thirty-six (36) months in accordance with regulatory requirements, accreditation and Ultimate's policies and procedures. The Provider will need to complete an Ultimate re-credentialing application or update their CAQH application, along with the requested documentation in order to maintain participating network status with Ultimate.

The Credentialing Committee will approve, deny, or modify the Provider status according to established policies. The Provider will be notified of the outcome by way of a letter.

Credentialing Committee

The function of the Credentialing Committee includes Provider credentialing and re- credentialing, and ongoing and periodic performance assessment. The Committee is comprised of the Ultimate Medical Director along with a quorum of physician voting Members. The Credentialing Committee meets monthly (or as the need arises) to determine the participation status of new Providers or those Providers who presently participate with Ultimate. The Credentialing Committee maintains the confidentiality of information obtained during the credentialing process and follows all policies and procedures implemented by Ultimate.

Professional Liability Insurance

Providers are required to carry and maintain professional liability insurance with the minimum limits of $250,000/$750,000. If the Provider decides not to obtain malpractice insurance, then the Provider must comply with State Statute 458.320 and submit, along with the credentialing application, the appropriate documentation. If the Provider selects to “go bare,” a notice must be posted in the office, in a conspicuous place, as required by F.S.458.320.

Site Visit Evaluation

As a requirement of the initial credentialing and re-credentialing process a site visit may be required. In these instances, the Provider must have adequately passed the evaluation in order to continue with the credentialing and re-credentialing process.

Role of the Physician Extenders

Providers may utilize the services of a physician extender such as a Physician Assistant (PA), Osteopathic Assistant (OA), Advanced Registered Nurse Practitioner (ARNP) and/or a Certified Nurse Midwife (CNM). These individuals may provide direct patient care to a Member under the supervision of a participating Provider. Physician extenders must undergo the same credentialing process as physicians. Scope of practice is limited to the rules and regulations established by the state of Florida, the physician extenders license and the policies and procedures set forth by Ultimate. Physician extenders should clearly identify themselves to Members, as well as to other health care professionals. A Provider must honor any request by a Member who requests to be treated by a physician, rather than a physician extender.

Network Status Review Process

The Network Status Dispute Committee (NSDC) is a sub-committee of the Administrative Dispute Resolution (ADRC), which convenes to resolve disputes regarding denial of participating status or a change in the network status of a participating provider for administrative reasons. Please see the section 8, Provider Complaints (Disputes) for further information.

Ultimate participating providers may register a complaint verbally or in writing (fax or mail) and/or by email at GrievanceandAppeals@ulthp.com.

Administrative Appeals & Reconsiderations

A participating provider can request an appeal for reconsideration of a decision relating to administrative matters or affecting the participation status within Ultimate network. Examples of disputes include but not limited to:

- Related to timely filing of claims.
- Failure to submit medical records in a timely manner.
- Reimbursement, Accessibility issues.
- Incidental procedures.
- Bundling and unbundling.
- Unlisted procedure codes and non-covered codes.
- Changes on network status unrelated to professional competency or conduct.

An administrative appeal review where a denial has been issues for reasons such as but not limited to:

- No prior authorization.
- Benefits exhausted.
- Service exceeds authorization.
- Days billed exceed authorization.
- Payment error/not authorized.
- Authorization expired.
- Requires authorization.
- Lack of medical information.
- Late notification.

The scope of the administrative dispute process does not include medical necessity or those related to actions regarding quality of care and/or member safety issues or changes in participation status related to professional competency or conduct; the medical necessity appeal process and peer review processes are in place to address such disputes.

The Administrative Dispute Resolution Committee (ADRC) is a committee that provides a mechanism to address alleged violations by participating providers of the requirements of Ultimate. The ADRC reports directly to the Quality Management Steering Committee (QMSC) and is scheduled to meet an ad hoc bases and provides a timely dispute resolution process.

The Network Status Dispute Committee (NSDC) is a sub-committee of the ARDC which convenes to resolve disputes regarding a change in the network status of a participating provider for administrative reasons.

Ultimate operates and provides the participation of individual physicians, groups of physicians through reasonable procedures that include:
Written notice of rules of participation including terms of payment, credentialing and other rules directly related to participation decisions.

- Written notice of materials change in participation rules before the changes are put into effect.
- Written notice of participation decisions that are averse to physicians.
- A process to present information and their views on the decisions.

Providers are encouraged to make inquiries of an appropriate department to address issues prior to submitting a dispute request, for example, to contact the Claims Department with EOB questions and possible immediate resolution.

Ultimate provides the disputing provider the opportunity to submit written documents, records and other pertinent information relating to the issue within fourteen (14) calendar days of the request. Information submitted will be considered during the process without regards to whether such information was submitted or considered in the initial consideration of the subject dispute. If the requested information is not received within the timeframe, the reviewer will decide based on the evidence in the case file.

Ultimate's timeframe for providers to submit a written request for dispute, dispute resolution and time frame to send written notification of the outcome to the provider are as follows:

- Process begins from the date the request is received by Ultimate.
- Disputes following a ***change in network participation*** status must be filed within five (5) business days of notification of the change. Ultimate will convene with NSDC committee within twenty (20) business days and notification of the outcome is mailed within three (3) business days of the decision.
- Disputes **NOT** involving a change in participation status are to be submitted within sixty (60) calendar days of discovery of the subject of dispute. Ultimate will convene the ARDC committee and notification of the outcome, when the original dispute is upheld, is sent to the disputing provider via mail within sixty (60) calendar days of receipt of the original request.
- For decisions found in favor of the provider, notification is made and decision effectuated within thirty (30) calendar days of the favorable decision but no greater than sixty (60) calendar days of receipt of the dispute request.

Claim-Related Complaints

Providers have sixty (60) days from a claim denial to file a Provider complaint. Complaints filed after that time will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the Provider feels they have filed their case within the appropriate time frame, they may submit proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Ultimate, or similar receipt from other commercial delivery services.

All Provider complaints will be thoroughly investigated using applicable statutory, regulatory, and contractual provisions, considering information submitted with the complaint, as well as information already available to Ultimate and applying Ultimate written policies and procedures. Ultimate will also ensure that the appropriate decision-makers with the authority to implement corrective action are involved in the Provider complaint process. In the event the outcome of the review of the Provider complaint is unfavorable to the Provider, Ultimate shall provide a written notice of the decision, as well as available avenues for appeal of the decision.

A Provider may also contact Ultimate Provider Services Department where dedicated staff is available to answer questions, assist in filing a provider complaint and attempt to resolve any issues. They are available anytime between 8 a.m. to 5 p.m. EST, Monday through Friday, excluding state holidays, or leave a message after hours, which will be addressed, and a phone call returned on the next business day.

Ultimate is not responsible for payment for medical records generated because of a Provider complaint. Any invoices received by Ultimate for such charges will be redirected to the Provider.

Provider complaints are reviewed using the CMS guidelines or applicable regulatory standards, medical review criteria, and other established guidelines as established by Ultimate to make a decision.

Full or Partial Claim Denial for Lack of Clinical Information:

- In the event the received documentation establishes medical necessity according to the above criteria, the nurse reviewer will approve the claim.
- If the nurse reviewer determines that the complaint does not meet criteria, the complaint is referred to the Medical Director or designee to provide a determination regarding the medical necessity of the claim.
- The Medical Director or designee is a physician with a valid, non-restricted Florida license to practice medicine who has the clinical expertise to provide review decisions.
- The same physician who issued the initial denial based on lack of clinical information is permitted to review the new information submitted with the complaint and decide medical necessity.

Full or Partial Claim Denial for Lack of Medical Necessity:

- If the original denial was for lack of medical necessity, the complaint will be reviewed by a physician reviewer who was not involved in the original denial decision.

Documentation

A complaint log will be maintained which will document:

1. The type of complaint.
2. Receipt date.
3. Decision.
4. The dates upon which acknowledgement of receipt and notification of decision letters were sent.

Notification

Within five (5) business days of the decision, but in no cases later than sixty (60) days after receipt, the complaining Provider will be notified by letter of the decision. If the decision is unfavorable to the Provider, information in the notification letter will include the process to appeal to the Florida Provider and Managed Care Organization Claim Dispute Resolution Program.

To submit an administrative dispute request, provider can submit a Participating Provider Dispute Resolution Request Form via the website www.chooseultimate.com.

Request may be submitted via:

- Mail to Address: Ultimate Health Plans, Inc.
  Grievance and Appeals Department
  P.O. Box 6560, Spring Hill, Florida 34611
- Fax to: (352) 352-7169; or
- Email to: GrievanceandAppeals@ulthp.com

Access to the Health Services Department
Providers will be able to access the Health Services Department Monday through Friday from 8:00 a.m. to 5:00 p.m. During after hours, weekends and holidays the on-call nurse will be available to aid with urgent and emergency health services to Members.

Physician Referrals

At Ultimate Health Plans we believe that the PCP is the patient's "Medical Home." PCPs may refer Members to Plan Specialists (except for Pain Management which requires Prior Authorization) when services will be rendered in an office, clinic, or free-standing facility by either a written or faxed script to the Specialist.

The Specialist must record the receipt of the Referral and the reason for the referral in the Member medical records. No communication with the Plan is necessary.

The PCP should require the Member to return to their office to discuss the recommendations of the specialist. The PCP will communicate the necessary authorization number to the Specialist. Referrals by a Specialist to another Specialist are not permitted.

Member Self-Referrals - Members may "self-refer", meaning no documented referral from the PCP is necessary, for the following services:

- Annual Well-Woman exam (breast exams, mammograms, PAP tests and pelvic exams).
- Behavior Health/Substance Abuse.
- Chiropractor.
- Dermatologist – See Quick Reference Guide for list of minor procedures and testing allowed during visit (Limit 5 visits per year).
- Dialysis when Member is temporarily outside the service area.
- Flu shots, Hepatitis B and pneumonia vaccinations.
- Emergent/Urgently needed care.
- Optometry.

Physician Authorizations

Specialist must coordinate with PCP for all services that require Prior Authorization. Please refer to the Quick Reference Guide and Authorization Process Overview in the "Forms & Resources" Section of this Provider Manual to identify what services require Prior Authorization.

The Ultimate "Prior Authorization Form" is located on the Ultimate website at www.chooseultimate.com. This form must be completed and faxed, along with supporting documentation process request to the Health Services Department at (352) 515-5975.

Contracted Networks - Authorization Protocol

Ultimate has subcontracted with certain networks. For a current listing of these vendors, please refer to the "Contracted Networks" Section of this Provider Manual.

All Providers are required to adhere to specific network protocols. Please refer Members to the Member Services Department if they have any further questions.

Non-Participating Provider Referral/Authorization Requests

All requests to use a non-participating Provider or Facility require a prior authorization from the Health Services Department, except in limited circumstances, such as Emergency care.

Emergency Room Notifications

Ultimate does not require emergency room authorizations for emergency room visits. Members should be encouraged to contact their PCP prior to going to an emergency room, except in the case of true emergencies. If a Member is seen in the emergency room and the PCP is notified, then it is the responsibility of the PCP to schedule a timely follow-up visit in his/her office.

Overview

Ultimate Health Plans, Inc. (Ultimate) Quality Improvement is a comprehensive program designed to promote high quality care and service excellence. The overall goal is to maximize and optimize the cost-effective delivery of care with the best possible health outcomes for our Members. The program helps with monitoring and evaluating current practices and implementing quality improvement initiatives.

The program provides the foundation for fulfilling regulatory and statutory requirements of the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Administration (AHCA) and the National Committee for Quality Assurance (NCQA). Ultimate and participating Providers are required to participate in specific reviews and tasks applicable to state and federal regulatory guidelines which are geared towards improving care for beneficiaries enrolled in managed care.

Data Collection/Monitoring

Monitoring activities are designed for a broad range of health care issues with focus on identifying areas of needed improvement in clinical, administrative, and financial areas. The ongoing monitoring of these activities will include reviews of compliance with clinical and administrative standards, as well as with accrediting agencies. This data is obtained by:

- Conducting Provider site visits.
- Evaluation of Member outcomes.
- Trending of administrative data.
- Review of target diagnoses and sentinel events.
- Trending of Member and Provider complaints, grievances and appeals.

Participation in the Quality Improvement Program

Providers play an integral role in the implementation of the Quality Improvement Program and are expected to understand and acknowledge the policies and procedures set forth by Ultimate. Providers are required to cooperate with our Quality Improvement Department; in doing so, Providers will be requested to cooperate with access to the medical records of current or previously enrolled Members, as permitted by state and federal law.

The Quality Improvement Program includes, but is not limited to:

- Medical records review.
- HEDIS review.
- Focus studies.
- Member satisfaction surveys.
- Peer review investigations.
- Complaint inquiries.

When documentation is presented and there is an opportunity to improve a Member's care, Providers may be asked to participate in formulating the care plan, as collaborative input will provide the means for a workable solution.

The Quality Improvement Department will assess the guidelines of care and documentation required by regulatory agencies and accreditation organizations for medical record review, health-screening and high-risk diagnoses on an ongoing basis. A Quality Improvement Representative will conduct this. Providers will be advised of any deficiencies found during the review. This review will assist Provider offices with making any necessary corrections. A "Corrective Action Plan" will be requested for all deficiencies.

Results of all reviews will be made part of the Provider's file and maybe presented upon re- credentialing of the Provider.

Medicare Advantage Chronic Care Improvement Program (CCIP) and Quality Improvement Project (QIP)

The Center for Medicare and Medicaid Services requires Medicare Advantage plans to have an ongoing quality assessment and performance improvement program. This program must include assessing performance using standard measures required by CMS and reporting its performance to CMS.

Chronic Care Improvement Program (CCIP)

Ultimate chose Controlling High Blood Pressure as its Chronic Care Improvement Project. This condition is directly related to the Million Hearts initiative as the targeted focus on the "ABCS". Controlling High Blood Pressure is an important step in preventing cardiovascular disease. Interventions to lower blood pressure can be an effective way to improve longevity and other health outcomes. Centering on Hypertension, the program will include ongoing disease/care management towards achieving blood pressure control and preventing related conditions and complications.

Program expectations for Members with diagnosis of Hypertension include increasing the number of members with a controlled blood pressure (<140/90 mm/Hg), increasing disease/care management interventions, and increasing anti-Hypertension medication compliance.

Quality Improvement Project (QIP)

Ultimate chose All Cause Readmissions as its Quality Improvement Project. Post-discharge support and Patient Education are two interventions that Ultimate concentrated on to reduce hospital admissions.

Post Discharge support -The strongest evidence is in the use of more stringent follow-up after discharge.

- Telephonic outreach calls post-discharge by Case Management Coordinator
- Setting appointment to PCP/Specialist within 1-2 weeks
- Home visit evaluation/programs, Tele-monitoring
- Report findings to PCP/specialist
- Referral to Social Worker – community resources, Advance Directive/Physician Orders for Life-Sustaining Treatment

Patient education and self-management support.

- Referral to CM/DM programs, chronic self-management classes and promotion of preventive health measures.

Member Health Education

Providers are expected to provide health education to Members on topics which are reflective of the demographics, local culture and health needs of the population served. Members with specific health education needs should be provided with access to health education resources, programs, or services for appropriate health education.

Appropriate Education:

- Improves and maintains the Member's physical and emotional state.
- Empowers Members to develop healthy lifestyle choices.
- Is founded upon accepted evidence-based medical principles, standards, and practices.
- Is accountable and responsive to Member concerns and grievances.
- Is accessible to Members.

Member Satisfaction

Ultimate will participate in regulatory Member Satisfaction Surveys, as well as monitor Member satisfaction with internal communications and data. Member satisfaction data and surveys are used to track and trend Member satisfaction and identify opportunities for improvement initiatives by using the continuous quality improvement process.

Preventive Health Services

Ultimate strongly encourages the implementation of preventive services as a mechanism for ensuring Member's good health and quality-of-life. All Members shall receive age-appropriate preventive health screens and assessments as indicated by current guidelines.

All Primary Care Physicians (PCPs) are provided with established current preventative guidelines and are required to adhere to those guidelines in administering health care services to Ultimate Members. Ultimate will monitor the extent to which PCPs are adhering to these set guidelines.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted on August 21, 1996, to establish a set of national standards for the protection of certain health information. HIPAA applies to all covered entities which electronically transmit medical information such as billing, claims, enrollment, or eligibility verification:

- Health Plans
- Health Care Clearinghouse
- Health Care Providers/TPAs
- Business Associates

For more information and training materials about Health Information Privacy and HIPAA, please visit the US Department of Health & Human Services (HHS) website at https://www.hhs.gov/hipaa/index.html .

Privacy of Individually Identifiable Health Information (PHI)

The Privacy Rule protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information *"protected health information (PHI)."*

"Individually identifiable health information" is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition,
- The provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, social security number).

US Department of Health & Human Services (HHS) Standard

The HHS establishes standards and guidelines for the privacy, security and electronic exchange of Protected Health Information which is collectively known as "Administrative Simplification".

Administrative Simplification Provisions

The provisions of Administration Simplification must be adhered by all Providers and establishes national standards for electronic health care transactions and national identifiers for Providers, health plans, and employers, and security and privacy of health data.

Advance Directives/Living Will

The Patient Self-determination Act, under Florida law, allows patients to make decisions about their medical care. The law recognizes the right of a competent adult to make an advance directive that:

- Instructs his or her physician to provide, withhold, or withdraw life-prolonging procedures.
- Designates another individual to make treatment decisions if the person becomes unable to make his or her own decisions.
- Indicates the desire to make an anatomical donation after death.

The Member can make an Advance Directive by completing a "Living Will" or a "Designation of Health Care

Surrogate" form provided on the Ultimate website, www.chooseultimate.com.

Providers are expected to advise each Ultimate Member regarding his or her future health care needs and available options. Providers may give advance directive information to the patient's family or surrogate should the patient be incapacitated at the time of enrollment.

Providers should ensure:

- On the first visit, as well as during routine office visits as appropriate, discuss the Member's wishes regarding Advance Directives for care and treatment and advise the Member to complete an Advanced Directive/Living Will if they have yet to do so.
- If asked, provide the Member with information about Advance Directives.
- Document in a prominent part of the Member's medical records whether the individual has executed or refused an Advance Directive.
- Do not discriminate against the individual based on whether he or she has executed an Advance Directive/Living Will.
- Should a Member have an executed Advance Directive/Living Will, you should include a copy of it in the medical record

HEDIS®

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to rate Plan performance. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA) to evaluate consumer health care. HEDIS data collection pertains to all Members enrolled in Ultimate's Medicare Advantage Plans.

According to NCQA, HEDIS includes more than 90 measures across 6 domains of care:

- Effectiveness of Care.
- Access/availability of Care.
- Experience of Care.
- Utilization and risk adjusted utilization.
- Health plan descriptive information.
- Measures collected using electronic clinical data systems.

Ultimate closely monitors provider performance in specific measures. For additional information regarding these measures, please contact Provider Relations.

Medicare Risk Adjustment (MRA) & Processing System (RAPS)

Overview

Medicare Risk Adjustment (MRA) is a CMS process used to formulate accurate Plan reimbursement (Member Premiums) based upon the Member's health standing. The Medicare Risk Adjustment Processing System (RAPS) is the CMS database used to store and process the diagnostic data submitted by our MA Plan.

The sicker the Medicare Member, the higher the Member's Premium to Plan will be to cover the higher costs for expected care. Care needs are identified by Diagnosis/HCC (Hierarchical Condition Category) Codes captured in Member's encounter data (including but not limited to: Claims; Medical Records/Progress Notes; Health Risk Assessments).

Premium Impact

Data collection is a 12-month period from which CMS uses the Diagnosis/HCC codes when calculating risk scores. For mid-year and final risk scores, the data collection period is the calendar year prior to the payment year (2020 for 2021 payment year). For initial risk scores (those used for prospective payments from January – June in a payment year), the data collection period is the July (two years prior) – June (in the year prior to payment year).
Example: For 2022 initial risk scores, CMS used July 1, 2020 – June 30, 2021, for the data collection period.

Guidelines

1. Unless directed otherwise by CMS, Diagnosis/HCC codes can only be captured by face- to-face encounters with a MD, PA, or NP at least once each year.
2. Chronic conditions (i.e.: Diabetes COPD, Amputations, ALL Psychiatric Codes, Alcohol and Drug Dependency/Remission) must be assessed and documented by encounters yearly for adjustments to be captured and processed.
3. Reported Diagnosis must be supported with medical record documentation.
4. Medical records and codes are subject to CMS Validation.
5. Documentation must be: Clear; Concise; Consistent; Complete; and Legible.
6. Scrub Member EMR/Progress Notes - Use SOAP (Subjective, Objective, Assessment, and Plan).

A. Subjective Components: Describes patient's current condition in narrative form:

- **Chief Complaint is required element** - Record patient experience of symptoms/problem/condition/physician recommended follow-up in their own words.
- **History of Present Illness** - Chronological description of present illness including the following:

Location	Timing
Quality	Context
Severity	Modifying Factors
Duration	Associated Signs and Symptoms

- **Review of Systems** - Inventory of body system functions through series of questions to assist in identifying signs and symptoms. Constitutional Data (i.e.: height, weight, BMI) is required on ALL Patients; the following are additional recognized systems:

ENT	Integumentary (skin and/or breast)
Neck	Neurologic
Cardio	Psychiatric
Respiratory	Endocrine
Gastro	Hem/Lymphatic
Genitourinary	Allergic/Immunologic
Musculoskeletal	

There are three levels used for recording:

1. **Problem Pertinent:** Review of Systems inquire about the system directly related to the problem(s) identified in the History of Present Illness.

2. **Extended:** Review of Systems inquire about the system directly related to the problem(s) identified in the History of Present Illness and a limited number of additional systems.

3. **Complete:** Review of Systems inquire about the system(s) directly related to the problem(s) identified plus all additional body systems.
    - **Past, Family and Social History** - There are three areas under this review component:
        1. History: Patient's history with illness, operations, injuries, and treatments.
        2. Family History: Review of family medical events, including diseases which may be hereditary or placing patient at risk.
        3. Social History: An age-appropriate review of past and current activities.

There are two levels used for recording History:

I. **Pertinent:** Review of History directly related to the problem(s) identified in the History of Present Illness. *(Documentation Requirements – At least one specific item from any of the three history areas must be documented.)*

II. **Complete:** Review of History directly related to two or three of the Past, Family and Social History areas. *(Documentation Requirements – Established Patients: At least one specific item from <u>two</u> of the three history areas must be documented.*

Established Patients: At least one specific item from ALL the three history areas must be documented.)

B. **Objective Components:** Describes patient's current condition in narrative form.
   - **Chief Complaint is required element** – Record patient experience of symptoms/problem/condition/physician recommended follow-up in their own words.
   - **History of Present Illness** – Chronological description of present illness including the following:

Location	Timing
Quality	Context
Severity	Modifying Factors
Duration	Associated Signs and Symptoms

C. **Assessment Component:** A summary of the patient's diagnosis. For patients with chronic disease diagnoses, it is important to include at every visit.

D. **Plan Component:** This is the documentation capturing what the Provider will do to treat the patients concerns. The Plan should address each item of the differential diagnosis.
Include diagnostic and therapeutic plans as well as patient education notes (what was discussed or advised with the patient), and any timeframes for review and follow-up. Ensure all referrals/authorizations and labs are incorporated in this section, as well as a review of ALL Medications that the patient is currently taking (adding new from current visit, and removing medications that are no longer needed or will no longer be refilled).

Rules for CMS Validation

Ensure that all of the following is not overlooked after all your hard work to deliver quality care to your patients.

CMS Requirements for Progress Notes

1. **Identification Requirements – MUST DOCUMENT ON EACH PAGE OF RECORD**
   - Member Name
   - Member Date-of-Birth (DOB)
   - Date-of-Service (DOS)

2. **Date-of-Service (DOS)**
   - Must be signed with Credentials.
   - Dated by Physician or appropriate Physician Extender.
   - Electronic Signatures on EMR (locked if EMR.

3. **Physician Signature and Credentials**
   - Valid Signatures: Records must be validated within 48 hours after dictation has been transcribed.
     a) Handwritten Signature.
     b) Handwritten Initials.
     c) Electronic Signature w/ the required authentication by servicing Provider.
        - ☐ "Electronically signed by"
        - ☐ "Approved by"
        - ☐ "Completed by"
        - ☐ "Finalized by"
        - ☐ "Validated by"
   - Provider Credentials must be documented.

Non-Validated types of Diagnoses

Providers are NOT to submit a diagnosis in the process of becoming confirmed - ALL diagnosis must be confirmed prior to submittal. The below are examples of inappropriate types of diagnosis submittals:

- Probable
- Suspected
- Questionable
- Rule Out Working

Coding

Code to the highest level of specificity.

Rules for NON-Validation

Do NOT overlook the below, as it will render your records non-valid for submittal.

Rendering a record as "Unable to Process"

Provider Signature missing
DOS missing
Progress Note missing
Illegible documentation
DOS is over 30 days prior to chart review
Attaching notes from previous year(s)
A Progress Note that doesn't match patient
Inaccurate/Questionable DOS
Agreeing to all codes under the same HCC

Rendering a record as "Incomplete"

Progress Notes submitted do not validate
Plan of Care missing
Care issues not addressed
Medication Listing is not noted/updated
Illegible documentation

Medical Record Documentation Standards (Requirements & Guidelines)

Providers are required to maintain a complete medical record for every Ultimate Member for whom they provide care. Provider shall maintain standards set forth by, but not limited to, accrediting agencies, Ultimate, and state and federal regulatory requirements and guidelines which apply to medical records documentation and standards.

Ultimate Providers will ensure that their office personnel will maintain the following:

1. Confidentiality, security and physical safety of medical records.
2. Timely retrieval and distribution of medical records upon request between Provider and Ultimate.
3. Unique identification of each Member's medical record.
4. Supervision of the collection, processing, maintenance, and storage of medical records.
5. Maintain a secured and organized medical record format.
6. Conduct periodic training in HIPAA Standards and Member information confidentiality.

Providers must have medical records procedures which address, but are not limited to, the following:

Contents of Medical Records

STD #	Standard	Specification
1	**Member name and biographical data**	Member name, identification number, gender, date of birth, phone number and address are recorded in the record.
2	**Member identification present on all pages**	All medical record pages include member identification information; name and ID number.

3	**Communication needs**	Assessment for special communication needs documented.
4	**Entries signed and dated**	All clinical entries, triage notes, addendum notes are dated and signed. Authors of entries are identified by profession, *e.g.,* MD, DO, RN, MA, etc.
5	**Entries legible**	Record is legible to the reviewer Company representative or office staff that is available to assist with the review. Illegible records that cannot be audited should be copied and submitted with the audit report.
6	**Allergies documented**	Allergies, or the absence of allergies, are prominently noted in the record. With the documentation of allergies, the type of adverse reaction is noted in the record at least once.
7	**Advance directive documentation**	Documentation includes whether or not the member has executed an advance directive. The advance directive or education regarding advance directives should be documented in a prominent part of the current record and easily found.
8	**Medical history documented**	A health history, to include current medications, is documented.
9	**Significant medical conditions and surgical events are documented on a problem list**	A problem list is maintained and includes significant medical and surgical history. N/A if documented health history indicates no chronic conditions or significant surgical history.
10	**Tobacco/substance use/abuse noted**	Risk assessment includes documentation of tobacco, alcohol and drug use/abuse.
11	**Subjective complaints documented**	Chief complaint or purpose of the visit is documented.
12	**Objective findings documented**	Objective findings appropriate for the chief complaint are documented.
13	**Diagnosis documented**	Diagnosis or clinical impression consistent with findings is documented.
14	**Treatment plan documented**	Plan of care, to include prescribed medications is documented at each visit.
15	**Member education documented**	Member education regarding plan of care and patient risk factors is documented.
16	**Unresolved problems addressed**	Unresolved problems from prior visits are addressed at subsequent visits. N/A if there are no problems or no unresolved problems.
17	**Consultant and diagnostic test results initialed and filed**	Evidence that ordered consultations and diagnostic testing were accomplished and results reviewed by the PCP. Reports are initialed by provider. Filed or verbal reports are acceptable: • Consult reports: allow 6 weeks;. • Lab, routine: allow 2 weeks • Lab, non-routine: allow 4 weeks • Radiology studies: allow 2 weeks N/A if none ordered
18	**Emergency room and hospital discharge summaries present**	Information regarding emergency visits and hospitalizations is documented. Facility discharge summaries or progress note entries meet requirements. N/A for no known ER visits or hospitalizations.

To comply with regulatory and accreditation requirements, scheduled medical record audits may be conducted at Provider offices by Ultimate's Quality Improvement Department. The patient records will be reviewed for content and organization. Provider will be informed of the results at the time of the audit and, if indicated, a "Corrective Action Plan" will be instituted to correct any deficiencies.

Audit Review Criteria

The criteria utilized for medical records and quality-of-care standards is based upon regulatory requirements outlined by regulatory agencies, accreditation guidelines, accepted national organizations and are subject to change based upon nationally recognized practice guidelines.

Audit reviews in a Provider's office will include an exit review with the Provider and designated office staff. The Provider will be given the results of the audit review and, if warranted, a "Corrective Action Plan" addressing any deficiencies. Any area which is not compliant with regulatory standards will require a correction plan. The Corrective Action Plan will be given to
the Provider at the time of the exit review and must be executed by the Provider, then faxed or mailed to Ultimate within five (5) business days of the review. Should a Provider not acknowledge by signing and returning the corrective action plan in the allotted time, a final request will be sent to the Provider and any Member assignments will be deferred until the signed plan is received by Plan. Re-credentialing may not occur if the Provider has an outstanding plan-of-correction. A follow-up audit will be scheduled and conducted within a reasonable time frame to ensure all deficiencies are corrected and meet regulatory compliance.

Ultimate Health Plans is committed to Cultural Competency by improving health care through meeting the unique and diverse needs of all its Members. Our set of values, principles, policies, and structures formed will enable the Ultimate staff and Providers to work effectively cross- culturally.

At Ultimate, Cultural Competency will evolve and grow with the comprehensive needs of our network, ensuring that employees and Providers understand and value cultural diversity.

Goals and Objectives

The employees and Providers of Ultimate must possess the method, aptitude, and behavior to work cross-culturally in the delivery of healthcare services.

Employees and Providers must effectively provide services to Members:

- Respective of their cultures, ethnic backgrounds, race and religion.
- In a manner which recognizes, values, affirms and respects the worth of the individual, and protects and preserves their dignity.
- Removing all cultural or language barriers by providing or obtaining alternative communication methods, as needed.
- Utilizing culturally sensitive and appropriate educational materials based upon the Member's race, ethnicity, and primary language spoken.
- Increasing satisfaction with clinical care and services, while decreasing health care disparities in the minority populations we serve.
- Increasing the understanding of health issues, including diagnoses and treatment plans.
- Reducing potential liability from medical errors and Title VI (Civil Rights Act) violations.
- Increasing overall preventive healthcare services and education of health risk issues.
- Improving utilization of outpatient and inpatient services.
- Improving care and health outcomes for our Members.
- Enhancing the cost-effectiveness of service provision.
- Increasing market penetration by appealing to potential culturally and linguistically diverse Members; and
- Improving sensitivity to cultural diversity, understanding the Members we serve.

Our strategy includes:

- Development of an integrated system to provide the foundation for Cultural Competency, strategies and goals.
- Assessing and analyzing of Membership in areas served to:
    - Identify Member's health disparities based on cultural characteristics.
    - Collect data on race, ethnicity and language spoken by Members.
- Identifying the health care needs of the population from the claims and encounter data.
- Determining a Provider network based upon Member demographic data for cultural and linguistic needs.
- Development of a Provider network which mirrors the cultural and linguistic characteristics of Members and provides for culturally appropriate services to Members.
- Evaluating Provider offices for oral and written educational material and notices in languages which reflect the Membership.
- A Provider directory indicating the language spoken by Provider, so Members may choose a Provider who speaks their primary language.
- Emphasizing the importance of Cultural Competency as part of a Provider's initial in- service.
- Inform Providers of "Cultural Competency" educational opportunities available.
- Alternative communication methods which Ultimate will arrange for Provider with Members who have potential linguistic barriers.
- Ultimate may assist in arranging interpretation services, at no cost to the Member, when necessary to access covered services which include:

    - Verbal translation and/or verbal interpretation for those with limited English proficiency.
    - Sign language for the hearing impaired.
- Written materials which are available to Members in large print format.
- Telephone adaptation system (TTY) for Members who are hearing impaired.
- A hiring process which does not discriminate with regard to race, religion or ethnic background and strives to recruit diverse talent at all levels of management.
- Bilingual employees in all areas who have direct contact with Membership.
- Ensuring that the existing outreach and community-based organizations which support minorities, and the disabled are being utilized to their fullest potential by Members; and
- Ongoing monitoring and assessment (for example, Member/Provider surveys) to identify opportunities for improvement.

Educational Links & Training Tools

National Healthcare Quality & Disparities Report
AHRQ, a federal agency that operates under the DHHS, is charged with improving the quality of healthcare for Americans. AHRQ's annual publication track quality of healthcare and disparities related to the quality of and access to health care. The report provides a comprehensive national overview of these disparities and tracks the progress of activities to reduce them.
http://www.ahrq.gov/research/findings/nhqrdr/index.html

America's Health Insurance Plans (AHIP)
AHIP is a national association representing many American health plans and their Members. AHIP's website offers a variety of resources on health care policy, issue advocacy and consumer education.
https://www.ahip.org/

Think Cultural Health
Launched in 2004, Think Cultural Health is sponsored by the Office of Minority Health. The website features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS.
https://thinkculturalhealth.hhs.gov/

Health Care Language Services Implementation Guide
This Web-based interactive tool from the DHHS Office of Minority Health can assist with enhancing language access services to better serve their limited English proficiency patients and decrease disparities in access to health care.
https://hclsig.thinkculturalhealth.hhs.gov/

The Claims Department will process claims timely in accordance to the Provider Agreement and State and Federal Guideline. Claims information is available in the Provider Portal, accessible by visiting https://www.chooseultimate.com/Provider/Portals or contacting Provider Services at 1-888-657-4171.

Claim Format

Electronic/Paper Claims
Provider should be using the appropriate claim form.

- Most current version of CMS 1500 Form
- Most current version of UB-04 Form

To ensure timely and accurate processing, all applicable fields on the claim form should be completed.

Identification Numbers
NPI, Tax ID and Ultimate Member numbers must be included with all claim submissions for proper identification and adjudication.

- **Ultimate Member Number**
  Ultimate will generate a unique Member number as an identifier to use with all related issues, including claim inquiry.
- **National Provider Identifiers (NPI Number)**
  All transactions, including claims, must include the referring, rendering or attending, billing and facility Provider's NPI numbers, as required by HIPAA's NPI Final Rule administrative simplification. Information on NPI numbers is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand .
- **Tax ID Number**
  All claims must include the billing Provider's Tax ID number.

Claim Guidelines

- Providers are required to use the standard CMS codes for ICD10 (with the highest level of specificity), CPT, HCPCS and Revenue Codes.
- Claims should indicate procedure and gross-billed charges.
- Separate charges must be itemized on separate lines.
- Provider must only bill for services within their specialty.
- Valid modifier codes must be used according to state and federal guidelines.
- Reimbursement is based on the lesser amount of the contracted rate or the Provider's billed amount, less any co-payments, deductibles, and/or co-insurance due from the Member.
- For payment to be made directly to the Provider, the claim must include the Provider's original signature, "signature on file" or "assignment of file" stamp.
- Provider Medical records must be available upon Plan request to validate the scope of services provided and billed.

HIPAA

Ultimate is required by federal regulation to abide by the Health Insurance Portability and Accountability Act (HIPAA), which includes a series of administrative simplification provisions.

Claim Submission

All claims to Ultimate should be mailed or submitted electronically. For submittals and timely filing specifications, please refer to the applicable Florida laws, regulatory agencies, or the Provider Agreement.

- All claims, electronic or paper, are considered received as per the date stamped received at Ultimate.
- Claims must be submitted to the correct address. For information on where to send claims, please visit our website at www.chooseultimate.com. For your convenience, the Ultimate claims address and EDI Payer ID is indicated on our Member ID cards.

Claim Inquiries

Claim inquiries should be made no earlier than forty-five (45) days from the date of submission. The Ultimate Provider Services Department is also ready to assist at 1-888-657-4171.

Duplicate Claims

A claim should not be resubmitted unless it is determined by inquiry that the original claim was not received by the Claims Department after forty-five (45) days from initial submission.

Receipt/Payment of Claims

- **Paper Claims Submittal**
  A remit along with the payment or reason(s) for the denial will be sent to the Provider within Thirty (30) days of receipt of claim. Claim action notice and payment is made on the date the notice or payment was mailed or electronically transferred.

  If additional information is required for processing, a notice will be sent to the Provider requesting the additional documentation. Provider must submit the requested documentation to Ultimate within ten (10) days after receipt of notification or the claim will be denied as unclean.

Paper Claims Mailing Addresses:

Medical Claims Ultimate Health Plans PO Box 3340 Spring Hill, FL 34611-3340	**Dental Claims** Aflac Benefits Solutions ATTN: Claims PO Box 211276 Eagan, MN 55121	**Behavioral Health Claims** Carelon Behavioral Health (formerly Beacon Health Options) ATTN: Claims PO Box 1870 Hicksville, NY 11802
Hearing Claims 20/20 Hearing Care Network 2900 W Cypress Creek Rd, STE 4 Ft. Lauderdale, FL 33309	**Acupuncture & Chiropractic Claims** American Specialty Health PO Box 509002 San Diego, CA 92150	**Part D Rx Drug Claims** OptumRx PO Box 650287 Dallas, TX 75265
Vision Claims **(For services on or after 1/1/2023)** Premier Eye Care ATTN: Claims 6501 Park of Commerce Blvd, First Floor Boca Raton, FL 33487	**Vision Claims** **(For services prior to 1/1/2023)** Aflac Benefits Solutions ATTN: Claims PO Box 211276 Eagan, MN 55121	

- **Electronic Claims Submittal -** Payer ID: 77022
- **Electronic Claims Submittal for Argus -** Payer ID Florida: ARGUS and Payer ID Out of Florida: ARG01

Ultimate encourages filing claims electronically. Benefits of filing via electronic media include:

- Decrease in turnaround time for payment.
- Streamlines the billing process.
- Reduction in Costs for filing (for example, postage costs, forms cost, printing cost, labor);
- Confirmation of Receipt.
- Prompt Identification of omitted/incorrect information.
- Ability for Provider to quickly track number of rejected versus accepted claims.

Acknowledgement of claim receipt will be sent to the Provider's clearinghouse within twenty-four hours or the next business day. Ultimate will notify Provider of payment and/or denial within Thirty (30) days after the electronic receipt of the claim. Claim action notice and payment is considered to be made on the date the notice or payment was either mailed or electronically transferred.

***NOTE**: If clearinghouse converts the electronic submission to a paper claim, the payment rules for paper claims shall apply.*

A notice will be sent to the Provider for claims which are pended requiring additional information. Provider must submit the requested documentation to Ultimate within ten (10) days after receipt of notification or the claim will be denied as unclean.

Coordination of Benefits

When a Member has more than one insurer, a Provider must bill the primary plan and thereafter, bill the secondary insurer with a copy of the remit received from the Member's primary plan. Any balance due after receipt of payment from the primary payer will be reviewed by Ultimate for consideration. The claim must include a copy of the remit with Member's information and verification of amount of payment received from the primary payer. Ultimate will then process the claim and apply the COB rule or the Medicare crossover rule, whichever is applicable in order to process the claim.

***NOTE:** Ultimate payment as a secondary payer will not exceed the amount specified according to contract, less the primary payer's payment amount.*

Covering Physician Reimbursement

In the event a covering physician agrees to provide services to a Member, the covering physician shall:

- Agree to accept the payment terms negotiated under the Agreement between Ultimate and Provider for providing the services to a Member.
- Seek payment for capitated services provided to a Member from the Provider and not Ultimate.
- Not seek payment from the Member, with the exception of those services for which the Provider would have been permitted to collect from Ultimate pursuant to the Provider Agreement.

Professional/Technical Payment

Ultimate covers the professional and technical components of global CPT procedures. The appropriate professional component modifiers and technical component modifiers should be used on the claim form.

Multiple Procedure Reduction

When two or more surgical procedures are performed on the same date-of-service and are subject to the reduction list, only one of the surgeries will be considered as the primary procedure; the remaining procedures will be considered secondary and/or subsequent. Unless otherwise indicated in the Provider Agreement, Ultimate will process claims according to the Multiple Procedure Payment Reduction standards established by CMS.

Assistant Surgeon Payment

Only participating Providers may be used as assistant surgeons if the procedure is recognized (for example, by InterQual, CMS or other standards) as meeting the medical necessity requirements for an assistant surgeon. Non-participating Providers may require specific authorization from Ultimate. On-staff surgeons who are not participating Providers may be used to assist in the event of an emergency. Charges for assistant surgeon fees will not be reimbursed if an assistant surgeon is not approved to perform the procedure.

Encounters

Claims submitted under a capitation contract are usually referred to as encounter data. Encounter data can be submitted on CMS 1500 or UB-04 forms following the same rules as standard claim submissions. This requirement is mandated to meet the reporting requirements of Ultimate, as well as those established by regulatory agencies, accreditation standards and the Balanced Budget Act. Any capitated Provider who does not submit encounter data, is subject to corrective action measures and penalties under applicable state and federal Law and could be terminated as a participating network Provider.

Corrected Claims & Adjustments

If submitting a corrected claim, the claim should clearly indicate "*CORRECTED CLAIM*" and include the claim number it references correction to, so plan does not deny incorrectly as a duplicate. For claims which require adjustment due to incorrect payment and/or processing errors, Providers should contact the Provider Services Department at 1-888-657-4171 for assistance.

Providers will be required to submit the following information for review and possible adjustment:

- Copy of the remit with the claim number, Member's name, Member ID number and DOS indicated.
- Additional requested information, such as proof of timely filing, attached to the remit.
- Reason for adjustment request.

If a participating Provider has exhausted their efforts in contacting the Provider Services Department for reoccurring processing errors which require research and adjustments to no avail, please contact your Provider Relations Representative prior to timely filing, as they will further investigate the trend for possible system-loading errors.

Member Billing

Payment from Ultimate to Provider constitutes payment in full, except for applicable co-payments, deductibles, co-insurance and any other amounts listed as Member responsibility on the Remit/EOB. Ultimate's contracted Providers are not permitted to balance bill our Members. Providers who continually bill Members will be issued a written warning by the plan.

Provider may not bill Member for:

- The difference between actual charges and the contracted reimbursement amount.
- Services denied due to timely filing requirements.
- Covered services for which a claim has been returned and denied for lack of information and/or billing error.
- Provider fails to notify Ultimate of a service which required prior authorization.
- Covered services rendered which were not medically necessary, in the judgment of Ultimate.

Non-Covered Services

Members may be billed for non-covered services and items of convenience.

- Services may be billed only if a waiver is obtained from the Member acknowledging financial responsibility prior to services being rendered (for example, an “Advanced Beneficiary Notice” [ABN] for Medicare Members).
- Members may only be billed for co-payments, deductibles, co-insurance, and specific non-covered services.

Ultimate has contracted with OptumRx as the Pharmacy Benefit Management (PBM) organization to administer the pharmacy benefits. This is an important part of the Member's health care services and provider involvement is critical to the success of the pharmacy program. Protocol information and contact numbers are available in the Quick Reference Guide located on the Ultimate website, www.chooseultimate.com.

List of Covered Drugs (Formulary)

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a medical treatment program. Ultimate will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan network pharmacy, and other plan rules are followed. The formulary will be reviewed and modified as new pharmaceuticals are introduced and generic preparations become available. The formulary and formulary addendum may be viewed on Ultimate's website at www.chooseultimate.com.

The formulary applies only to medications obtained through outpatient participating pharmacies and does not apply to drugs used in the hospital, or while the Member is in a skilled nursing facility or hospice care.

Generic Drugs

Ultimate encourages the use of preferred generic name medications. The use of non-preferred generic and brand name medications may result in higher co-payments for the Members. Members may be required to use "step therapy" before non-preferred drugs will be considered. In accordance with Florida law, generic drugs will be dispensed by the pharmacist when a therapeutically equivalent to a brand name drug is available.

Prescribing Medication

To maximize the pharmacy benefit, Providers should adhere to the following guidelines when writing a prescription for the Member:

- Prescribe drugs from the formulary.
- Prescribe generic drugs when therapeutic equivalent drugs are available.
- Evaluate medication profile for appropriateness and duplication of therapy.
- Follow national standards of care guidelines for treating conditions.

Coverage Determination Process

The goal of the Coverage Determination process is to ensure that medication regimens that are high-risk, have a high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.

The Coverage Determination process is required for:

- Drugs not listed on the formulary.
- Drugs listed on the formulary with a prior authorization.
- Duplication of therapy.
- Prescriptions that exceed the FDA daily or monthly quantity limits or prescriptions exceeding the permitted noted on the formulary.

- Most self-injectable and infusion drugs (including chemotherapy) administered in a
- Physician's office; and
- Drugs that have a step edit and the first line therapy is inappropriate.

Coverage Determinations are decisions made by or on behalf of Ultimate regarding payment or benefits to which members believe they are entitled. Types of Coverage Determinations include:

- **Non-Formulary Exception:** An exception that allows members to have access to drugs that are not included on Ultimate's formulary.
- **Prior Authorization:** A requirement that certain clinical criteria be met prior to approval:
  - If the prior authorization (PA) criteria are met, this is reported as a PA.
  - If an exception to the PA criteria is made, this is reported as exceptions to Ultimate Health Services Department.
- **Quantity Limit Exception:** An exception that allows members to obtain a greater quantity of a medication than is generally allowed by Ultimate per prescription for a defined period of time.
- **Step Therapy Exception:** An exception that allows members to obtain a medication that is subject to approval only after failing a different clinically appropriate medication.
- **Tiering Exception:** An exception that permits members to obtain a non-preferred drug at the more favorable cost-sharing terms applicable to the drugs in Ultimate preferred tier; and
- **Formulary Exception:** A non-formulary exception, tiering exceptions, quantity limit exceptions and step therapy exceptions are all considered to be "formulary exceptions".

A Member, a Member's prescriber, or a Member's representative may request a standard or expedited coverage determination by filing a request with the PBM. The coverage determination or exceptions request forms are located on Ultimate's website, www.chooseultimate.com; or contact Member Services:

OptumRx
Prior Authorization Department
PO BOX 25183
Santa Ana, CA 92799
Phone: (800) 311-7517
Fax: (844) 403-1028

The physician, or prescriber, will be required to provide a supporting statement as to why the drug should be approved.

Requests for Benefits

When a party has made a request for coverage of a Part D drug benefit that *has not been received yet*, the PBM, on behalf of Ultimate, must notify the Member (and the prescribing physician or other prescriber involved, as appropriate) of its determination as expeditiously as the Member's health condition requires, but no later than 72 hours after the date and time the PBM, on behalf of Ultimate, receives the request for a standard coverage determination, or no later than 72 hours after receiving the physician's or other prescriber's supporting statement if the request involves an exception. For expedited coverage determinations and exception requests, the PBM, on behalf of Ultimate, must make the determination, whether favorable or adverse, and provide notice of its decision as expeditiously as the Member's health condition requires, but no later than 24 hours after receiving the request.

Requests for Reimbursement

When a party requests reimbursement for a Part D drug that a Member *has already received*, Ultimate must make the decision and provide notice of the decision as expeditiously as the Member's health

condition requires, but no later than 14 calendar days after receiving the reimbursement request.

If Ultimate is issuing an unfavorable reimbursement decision, it must make the decision, provide notice of the decision, and provide appeal rights to seek an appeal as expeditiously as the Member's health condition requires, but no later than 14 calendar days after receiving the reimbursement request.

Pharmacy Locations

In most cases, prescriptions are covered only if they are filled at the plan's network pharmacies. We have network pharmacies outside of our service area where Members can fill prescriptions. Generally, Ultimate covers drugs filled at an out-of-network pharmacy *only* when the Member is not able to use a network pharmacy.

Circumstances when Ultimate may cover prescriptions filled at an out-of-network pharmacy would include if an eligible Member is traveling within the U.S., but outside of the plan's service area, and becomes ill, loses or runs out of the prescription drug(s), Ultimate may cover prescriptions that are filled at an out-of-network pharmacy if the Member follows all other coverage rules identified within the Evidence of Coverage (EOC) document and a network pharmacy is not available. In this situation, the Member will have to pay the full cost (rather than paying just the co-payment or coinsurance) at the time the prescription is filled.

Prior to the Member filling the prescription at an out-of-network pharmacy, Members should call Member Services to find out if there is a network pharmacy in the area where they are traveling. If there are no network pharmacies in that area, Member Services may be able to make arrangements for the Member to get their prescription from an out-of-network pharmacy.

Member Co-Payments

Member will be responsible for all applicable co-payment/co-insurance/deductible and non- covered medications as per the Member's Summary of Benefits.

The co-payment and/or co-insurance are based on the drug tier and the Member's subsidy level. Refer to the Member's "Summary of Benefits" for the exact co-payment and co-insurance located at www.chooseultimate.com.

Over-the-Counter (OTC) Medications

Medications available to the Member without a prescription (for example, over-the-counter) are not eligible for coverage under Medicare Part D. However, Ultimate offers an over-the-counter benefit at no cost to the Member for certain drugs. Benefit information is available at www.chooseultimate.com.

Medication Appeals

To request an appeal of a Coverage Determination decision, contact:

Attn: Prior Authorization Dept.
c/o Appeals Coordinator Address:
P.O. Box 25184 Santa Ana, CA 92799
Phone: (800) 311-7517
Fax: (877) 239-4565

Once the Coverage Determination decision has been properly submitted, the request will follow Member Grievances and Appeals, Section 15 of this Provider Manual.

Ultimate is committed to providing quality care and maintaining Member satisfaction. As such, we encourage our Members to communicate any problems they may encounter with Ultimate services, staff and/or our network providers.

All Member complaints, grievances, and/or appeals will be processed in accordance with the appropriate guidelines. Grievances are reviewed based upon applicable statutory, regulatory, and contractual provisions. Following Ultimate policies and procedures, Ultimate will collect pertinent facts from all affected parties and all relevant departments will participate to ensure that the necessary corrective actions are implemented.

Member Complaint

A Member, or a person acting on behalf of the Member, may express a complaint to Ultimate or to a state agency regarding any aspect of Ultimate operations and benefits, including dissatisfaction with administration, claims practices, and/or provision of services related to the quality of care provided by Ultimate and/or Provider either orally or in writing.

Ultimate encourages Members to voice any concerns by contacting a Member Service Representative. The Ultimate representative will make every effort to resolve the informal inquiry or Member concern before it becomes a formal complaint. Most Member inquiries or concerns are resolved at the time of initial contact by way of a phone call. If the Member is not satisfied with the resolution offered by the Member Service Representative, we have a Member Advocate Team available to bridge communications between Ultimate Health Plans Members, Providers, and suppliers. We are here to answer inquiries and help resolve concerns.

The responsibility of our Member advocate representative is to provide answers to basic inquiries concerning Ultimate Health Plans benefits, claims, referrals, formulary, Providers, and suppliers; as well as assisting with urgent care need, sooner appointment, changing Provider, and in-depth problem-solving assistance. Our Member Advocates are located at the below Hernando County location:

1244 Mariner Boulevard
Spring Hill, FL 34609
(352) 835-7151

The inquiry or concern will be forwarded to the Grievance and Appeal Department for further review and investigation.

Member Standard Grievance

Members, or a person acting on behalf of the Member, may file an oral or written grievance within 60 calendar days of the event or occurrence. The request along with supporting documentation should be submitted to the Grievance and Appeals Department via regular mail or fax (see contact information below).

If a Member wishes to use a representative, then she or he must complete a Medicare Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The AOR form is located on Ultimate‘s website at www.chooseultimate.com. Supporting documentation should be submitted to the Member Services

Department via regular mail or fax (see contact information below). Members may contact the Member Service Department to submit the information verbally or to request assistance and/or guidance at any time during the process.

Examples of Issues that may result in a grievance include, but not limited to:

- Provider Service including, but not limited to:
  - Rudeness by provider or office staff.
  - Refusal to see member (other than in case of patient discharge from office).
  - Office conditions.
- Services provided by Ultimate including, but not limited to:
  - Hold Time on telephone.
  - Rudeness of staff.
  - Involuntary disenrollment from Ultimate.
  - Unfulfilled requests.
- Access availability including, but not limited to:
  - Difficulty getting an appointment.
  - Wait time in excess of one hour.
  - Handicap accessibility.

Please include the Member's name, identification number, description of the occurrence, date of event or occurrence, the Member's signature, and date of signature. Written grievances can be mailed, faxed and/or sent by email to GrievanceandAppeals@ulthp.com. Ultimate's Grievance and Appeals Department address and fax number are listed below:

Ultimate Health Plans, Inc.
ATTN: Grievance & Appeals Department
P.O. Box 6560
Spring Hill, FL 34611
Fax: (800) 313-2798

The written grievance request is date-stamped on the day it is received, documented in Ultimate's internal system, and sent to the Grievance and Appeals Department. The Member's issue(s) will be researched, all medical records needed will be requested, inquiries will be made to all departments involved and all actions will be documented for record keeping.

Grievances received either verbally or in writing will be reviewed and finalized either orally or in writing no later than 30 calendar days from received date. Verbal notification is made to the enrollee that the grievance was received and will be investigated.

In accordance with regulations, extensions within the 14 calendar-day limit would be justified if:

a. Member requests an extension.
b. Additional information is required from non-contracted Providers and/or Providers outside of the service area and delay is, thereby, in the best interest of the Member.

If an extension is deemed necessary for reasons other than at the Member's request, prompt notification in a form of a letter will be sent to the Member explaining the status of the case and explain how the need for the extension is in the member's best interest. If required information has not been

received within the allowed timeframe, a determination will be made based upon the information

available.

Member Expedited Grievance

A Member may request an expedited grievance if Ultimate makes the decision not to expedite an organizational determination, expedite an appeal or invoke an extension to review. Ultimate will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review timeframe or extend a review timeframe does not jeopardize the Member's health.

Ultimate will contact the Member or the Member's representative via telephone with the determination and will mail the resolution letter to the Member or the Member's representative within 3 business days after the determination is made.

Appeals & Reconsideration

A Request for Reconsideration (Appeal) is a written or oral request by a Member (his/her legal guardian, authorized representative, or power of attorney), or a non-participating Provider, (who has signed a waiver indicating he/she will not seek payment from the Member for the item or service in question). A physician who is providing treatment to a Member, upon providing notice to the Member, may request an expedited or standard reconsideration on the Member's behalf without having been appointed as the Member's authorized representative.

To reconsider the Plan's Initial Determination to deny payment of a claim or authorize a service, a request for reconsideration must be received within 60 calendar days of receipt of an initial determination. A decision on a request for reconsideration must be expedited as the Member's health condition requires, but no later than 72 hours for situations where applying the standard time procedure could seriously jeopardize the enrollee's life, health or ability to regain maximum function, 30 calendar days for a standard service request and 60 calendar days if the request is for the Payment of a denied claim.

There are six (6) levels of the Appeals process:

1. The initial determination (organization determination).
2. Appeal Reconsideration.
3. Reconsideration by the Independent Review Entity.
4. Hearing by an Administrative Law Judge (ALJ), if at least $140.00 (amount in 2014) is in controversy.
5. Medicare Appeals Council (MAC).
6. Judicial review, if at least $1,760.00 (amount in 2022) is in controversy.

Appeals Process

A Request for Reconsideration (Appeal) is received within 60 calendar days of the adverse initial determination. If a Member's issue involves both an appeal and grievance, they are worked simultaneously.

In all cases, payment of claims or authorization for services and notification to Member/non- contracted Provider must be made within, 72 hours for expedited request, 30 calendar days for a standard request and 60 calendar days for payment of a denied claim. If sufficient information to make a determination is not received within the allowed processing time, a determination must be made based on the information received. (An extension of up to 14 calendar days can be made if requested by the Member or if the plan justifies the need for additional information and it is in the best interest of the Member).

Members will be advised of their right to file an expedited grievance should they not agree to the extension.

Ultimate is responsible for dismissing reconsiderations requests when appropriate and providing timely notification of dismissals to members or another party. Ultimate will inform the Members and other parties about the right to request an Independent Review of the dismissal. Ultimate will no longer automatically forward such reconsiderations cases to the IRE for review. Proper notification of Ultimate's decision to dismiss a reconsideration request will be sent to the Member or Member's representative on a Notice of Dismissal of Appeal Request form.

If a decision cannot be made or if the denial is upheld in whole, or in part, the issues that remains in dispute will be forwarded to be reviewed and resolved by the Independent Review Entity (IRE) along with written explanation of the decision for a new determination by the, 72nd hour, 30th or 60th day. The Member/appointed representative/treating physician/non-contracted Provider is notified in writing.

CMS's IRE will advises the Member/appointed representative/treating physician/non-contracted Provider and the plan of its decision in writing within the required time frames depending on the level of the appeal stating the reason(s) for the decision and inform the Member/non-contracted Provider of his or her right to a hearing before an Administrative Law Judge of the Social Security Administration if the denial is upheld and the amount in controversy meets the appropriate threshold requirement.

If the denial is overturned by IRE, the request for a service is provided as expeditiously as the Member's health requires but no later than 72 hours for an expedited appeal, 14 calendar days for a standard service appeal or 30 calendar days for a standard claim appeal.

Depending on the amount in controversy, the Member/non-contracted Provider may have the right to appeal IRE decision by requesting a hearing before an Administrative Law Judge (ALJ). The request must be submitted in writing within 60 days after the date of notice of the adverse reconsideration determination and must be filed with the entity specified in IRE reconsideration notice. If Ultimate receives a written request for an ALJ hearing from an enrollee, Ultimate must forward the enrollee's request to IRE. An adverse decision or case dismissed by the ALJ can be reviewed by the Medicare Appeals Council (MAC), either by its own action or as the result of a request form the Member/non-contracted Provider or Ultimate. If the MAC grants the request for review, it may either issue a final decision or dismissal, or remand the case to the ALJ with instructions. MAC review must be requested in writing within 60 days of the ALJ adverse determination.

Depending on the amount remaining in controversy, the Member/non- contracted Provider of Ultimate may have the right to request a Judicial Review. The review must be requested in writing within 60 days of the MAC's adverse determination.

The entity which makes an initial reconsidered or revised determination may re-open the determination.

Re-openings occur after a decision has been made. Re-openings may be granted:

- To correct an error
- In response to suspected fraud
- In response to the receipt of information not available or known to exist at the time the claim was initially processed

A re-opening is not an appeal right. A party may request a reopening even if it still has appeal rights, as long as the guidelines of the re-opening are met. For example, if a Member receives an adverse

determination, but later obtains relevant medical records, he or she may request a re-opening rather than a hearing before an ALJ. However, if the beneficiary did not have additional information and just disagreed with the reasoning of the decision, he or she must file an appeal. If a Member requests a reopening while he or she still has appeal rights, he or she will also file for the appeal and ask for a continuance until the re-opening is decided. If the re- opening is denied or the original determination is not revised, the party retains its appeal rights. The party that filed the reconsideration may withdraw that request. The withdrawal must be filed in writing to the Plan, the Social Security Office, or the Railroad Retirement Board office (for railroad retirees). The withdrawal will be acknowledged in writing by the Plan.

Part D Grievances

Ultimate has contracted with OptumRx as the Pharmacy Benefit Management (PBM) organization to administer the pharmacy benefits.

A Part D grievance is any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of the PBM, regardless of whether remedial action is requested. Grievances can be expedited or standard. Examples of a grievance could include, but are not limited to:

- Quality of customer service a Member receives.
- If a Member disagrees with Ultimate's decision to not expedite a coverage determination or redetermination.
- A decision is not given within the required timeframes.
- Waiting times while getting a prescription filled.
- Rude behavior by network pharmacists or other staff.
- Cleanliness or condition of network pharmacy.
- Ultimate benefit design.
- Dissatisfaction about co-pay amounts.
- Complaints about the calculation of TrOOP costs for Medicare Part D.

The PBM is available to answer inbound calls from members, pharmacies, and physicians and other prescribers who provide health care services to members.

Members or Providers with inquiries, questions regarding pharmacy benefits, co-payments, network pharmacies, status of Coverage Determination Requests or grievances/appeals relating to Part D medications may contact OptumRx at (800) 311-7517.

The PBM's Pharmacy Help Desk provides information related to claims processing, benefit coverage, claims submission, claims payment, and, if the pharmacy is not a network pharmacy, information on how to become a part of the pharmacy network. They also provide information on appeals, how to submit a Coverage Determination request, Medical Necessity Exception Request or Prior Authorization form (if appropriate), status of Coverage Determination requests, and other information in accordance with Ultimate benefit plans including specific utilization management requirements and procedures.

Members may file a grievance, or a grievance may be filed on the member's behalf by an authorized representative or a provider with the Member's written consent. Once a grievance is filed with the PBM, it is sent to Ultimate Grievance and Appeals Department for processing. Part D Standard and Expedited Grievances follow the same guidelines as noted above.

Part D Appeals

A coverage determination is any determination (i.e., an approval or denial) made by the PBM, with respect to the following:

- A decision about whether to provide or pay for a Part D drug (including a decision not to pay because the drug is not on Ultimate's formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because the PBM determines that the drug is otherwise excluded under section 1862(a) of the Act if applied to Medicare Part D) that the Member believes may be covered by the plan.
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the Member.
- A decision concerning a tiering exceptions request under 42 CFR 423.578(a).
- A decision concerning a formulary exceptions request under 42 CFR 423.578(b).
- A decision on the amount of cost sharing for a drug.
- A decision whether a Member has, or has not, satisfied a prior authorization or other utilization management requirement.

If a member disputes a coverage determination, the case is handled using the federally mandated appeals process.

If a member complains about any other aspect of the PBM's operations (for example, the manner in which a benefit was provided), the PBM must address the issue through the grievance process.

When the PBM decides not to provide or pay for a requested drug, in whole or in part, the decision is an adverse coverage determination. If the PBM makes an adverse coverage determination, it must provide the member with a written denial notice that includes his or her appeal rights.

The PBM is not required to treat the presentation of a prescription at the pharmacy counter as a request for a coverage determination. Accordingly, the PBM is not required to provide the member with a written denial notice at the pharmacy as a result of the transaction. However, as required under 42 CFR 423.562(a)(3), the PBM must arrange with their network pharmacies to distribute the standardized notice developed by CMS to notify members of their right to request and receive a coverage determination from their plan, this takes place at the point a prescription attempts to process.

To request an appeal of a Coverage Determination decision, contact:

Attn: Prior Authorization Dept.
PO Box 25183
Santa Ana, CA 92799
Fax: (877) 239-4565

Once an appeal is filed with the PBM, it is sent to Ultimate Grievance and Appeals Department for processing. Ultimate notifies the member and the prescribing physician orally or in writing as expeditiously as the medical condition requires, no later than 24 hours after receiving the request for an expedited appeal or no later than 72 hours after receiving the request for standard appeal.

When a physician has made a request for coverage of a Part D drug that has *not been received yet*, the PBM will notify the member and the prescribing physician of its determination as expeditiously as the members' health condition requires, no later than 72 hours after the date and time the PBM receives the request for a standard coverage determination.

Standard appeals that are completely “favorable”, members and/or their prescribing provider will receive a written notice of its decision as expeditiously as the member’s health condition requires, but no later than 7 calendar days from the date the Ultimate receives the request.

Case Management Program Overview

The Medical Care Management case management program is an integral part of the healthcare delivery system. Case management is a dynamic and systemic, collaborative approach to providing and coordinating health care services for patients. It has been found that early identification, stratification, and care coordination of high-risk patients will reduce hospitalizations and emergency room visits of the elderly and chronically ill. It will also improve medication adherence and will help close care gaps that can trigger or exacerbate health conditions. The program can help identify and facilitate options and services that will meet the patient's needs, decrease fragmentation and duplication of care, and facilitate cost effective clinical outcomes.

The care management program includes the following for individuals:

- Members who present with multiple chronic diseases/conditions.
- Members who have had a critical event or diagnosis that requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.
- Members who, during an inpatient admission, need care coordination during admission and discharge planning.
- Members who require assistance in transitioning in care such as from a hospital to the community, a nursing home or other institutional facility.
- Members who are at high risk for chronic disease because of health and lifestyle behaviors.

The Case Management process begins with identifying the candidate, following the member in the program, and ends upon discharging the member from the Program. Members may be identified for Case Management by several methods, including:

- upon completion a Health Risk Assessment.
- a referral from a member's PCP.
- self-referral.
- referral from a family member.
- hospitalization for transplant.
- through high utilization.

The program is designed to promote optimal wellness or improved functional capability for members in the most appropriate setting, while utilizing health care resources in a cost-efficient manner.

The Case Management Program defines its goals as follows:

- An interdisciplinary focus and continuity of care across diverse health providers.
- Early identification of Members.
- A comprehensive assessment of the Member's condition.
- An identified intake process.
- Empowers Members to independently direct care, self-manage and make decisions.
- Care plans will be developed in conjunction with the member and implemented that are specific to members' needs and have performance goals, monitoring and follow-up that will maximize each Members' outcome.
- Utilization of community resources, faith-based resources, governmental and social services and support groups to facilitate continuity of care, as appropriate and in the most efficient manner.
- Utilization of a written care treatment plan.
- Measurement of Members experience with the program, the program staff, program access and

availability and usefulness of information provided.
- Measurement of reported health outcomes by Members, such as Members' perception to manage their health, perception of their improved health status and functional status.
- Review of utilization and cost measures such as hospital readmissions, ER utilizations and return on investments.

Ultimate's Case Management Team is led by Registered Nurses who assess the Member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan. The Team also serves in a support role to the PCP and helps bring together the member with providers, medical services, social and other services as needed.

If a candidate is identified by Ultimate's Care Management Team, the Case Manager sends the Primary Care Physician a fax to notify him/her that the member has agreed to participate in Care Management services.

Services provided through the program include:
- Regularly scheduled telephone calls from a Care Management nurse.
- Health education materials to help the patient understand his/her condition, treatment, options, and benefits.
- Tips on understanding and following the PCP's instructions on:
  - Medications
  - Following a prescribed diet
  - Controlling the patient's condition
  - Preventive care needed based upon the patient's condition(s)
- Information on community and national resources:
  - Finding community resources to help with non-medical needs, such as transportation, meals, and support groups.
  - Contact information on national or local organizations that may assist the patient now or in the future.

Ultimate's Care Managers can be reached Mondays thru Friday's from 8AM to 5PM should you have any questions regarding the program or services provided.

Disease Management Program Overview

Ultimate's Disease Management Program is Available to Your Patients, Our Members.

Ultimate Health Plans has developed the cardiovascular disease and Diabetes Management Programs to assist your patients with Cardiovascular Disease and Diabetes to better understand their condition, update them on new information about their illness and provide them with assistance from our staff to help them manage their health. The program is designed to reinforce your treatment plan for the patient.

Members of Ultimate Health Plans do not have to enroll; they are automatically enrolled when we identify them as having cardiovascular disease or Diabetes. We will inform you of their participation. If you would like to enroll patients who are Ultimate Health Plans members but are not in the program, please let us know by contacting our Disease Management Program at 1- 855-337-6868.

The program provides the following services:

- Support from our nurses and other health care staff to ensure that your patients can understand how to best manage their condition and periodically evaluate their health status.
- Periodic newsletters to keep the patients informed of the latest information on cardiovascular disease and Diabetes as well as the management of these conditions.
- Educational and informational materials that can assist your patients in understanding and managing the medications you prescribe, how to effectively plan for visits to see you and reminders as to when those visits will occur.
- Information about upcoming events such as health fairs. We will also provide you with updates on the results of tests or other information that we collect on your patients.

Membership in the cardiovascular disease and Diabetes Management Program is voluntary. If at any time your patients wish to stop participating in the program, they need only call.

Ultimate Health Plans, Inc. (Ultimate) is fully committed to battling the fraud, waste and abuse that burdens our health care system. In full partnership with state and federal agencies, our organization strives to prevent, detect, investigate, and correct issues of fraud, waste and abuse. It is our mission to protect our Members, Providers, employees, business partners and stake holders and to work closely with law enforcement to fully prosecute violators of the law.

Ultimate is required to comply with all federal and state programs concerning fraud, waste, and abuse. These governing entities include, but are not limited to, the Agency for Health Care Administration (AHCA), Center for Medicare and Medicaid Services (CMS), and the US Department of Health and Human Services' Office of Inspector General (OIG) to establish policies and procedures to monitor and report the incidence of health care Fraud, Waste and Abuse. As such, participation, and adherence to all FWA policies and procedures are, and will continue to be, part of your agreement with Ultimate.

Defining Fraud, Waste and Abuse

Fraud: An intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to himself or another individual. It includes any act which constitutes fraud under applicable federal or state law.

Waste: Over-utilization of health care resources which result in unnecessary costs to the health care system. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

Abuse: Describes practices which are inconsistent with standard medical practices, resulting in an unnecessary cost to the Medicaid, Medicare Advantage or Medicare Part D programs. Abuse includes reimbursement for services which are either not medically necessary or fail to meet professionally recognized standards for health care.

Impact

To curb the negative impact that FWA has on our health care system, it is vital that Members, Providers, and health plans work closely on identifying, investigating and correcting known deficiencies.

Penalties and Liability

The False Claims Act (FCA)

The FCA (31 United States Code [U.S.C.] Sections 3729-3733) protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. An example may be a physician who submits claims to Medicare for medical services he or she knows were not provided. Civil penalties for violating the FCA may include fines and up to 3 times the amount of damages sustained by the Government as a result of the false claims. There also is a criminal FCA (18 U.S.C. Section 287). Criminal penalties for submitting false claims may include

fines, imprisonment, or both. For more information on fraud, visit https://oig.hhs.gov/fraud/ .

Anti-Kickback Statute

The Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Where remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by a federal health care program, the Anti-Kickback Statute is violated. If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute. The safe harbor regulations are set forth at 42 Code of Federal Regulations (CFR) Section 1001.952. Criminal penalties for violating the Anti-Kickback Statute may include fines, imprisonment, or both. For more information, visit https://oig.hhs.gov/compliance/safe-harbor-regulations on the Internet.

Stark Law

The Physician Self-Referral Law (Stark Law) (42 U.S.C. Section 1395nn) prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an immediate Member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement unless an exception applies. Penalties for physicians who violate the Physician Self-Referral Law (Stark Law) include fines as well as exclusion from participation in all Federal health care programs. For more information, visit the Centers for Medicare & Medicaid Services website at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral .

Examples of FWA

Up-Coding
Billing for a higher level of service than was provided. Up-coding mainly occurs in the outpatient setting through use of Evaluation and Management (E & M) CPT Codes.
Services Not Rendered (SNR)
Billing for a service that was not provided. Beneficiary review of the Explanation of Benefits (EOB) is critical to the detection of SNR. Across the entire health care system, this tends to be the number one allegation for both Medicare and Medicaid benefits.
Overutilization
Providing a medically appropriate service based on the condition being treated, however providing the service more frequently than is needed.
Lack of Medical Necessity
Providing a service that is not necessary based on the condition being treated; an example is providing quantitative testing when the qualitative result was negative.
Unbundling
Billing separately for the packaged (or bundled) services of the primary procedure. The classic example is a laboratory panel, which is comprised of multiple component tests. Instead of billing the panel code, the billing personnel list each individual CPT code.

Exclusion/Sanction/Debarment Checks

All Providers and Affiliates must review federal exclusion lists (HHS-OIG and GSA) at the time of hire/contracting with their current employees/contractors, health care professionals, or vendors that work on Medicare Advantage, Part D or Medicaid programs to ensure that none are excluded from participating in Federal health care programs. For more information or access to the publicly accessible

excluded party online databases, please see the following links:

- Health and Human Services – Office of the Inspector General (HHS-OIG) List of Excluded Individuals / Entities: http://oig.hhs.gov/exclusions/index.asp
- General Services Administration (GSA) Excluded Parties List System (EPLS) is accessible through the System for Award Management (SAM) site: https://www.sam.gov/SAM/pages/public/index.jsf

Your Responsibility: *Review applicable exclusion/sanction/debarment lists to ensure that none of your employees or contractors are excluded from participation in federal health care programs. If you discover that one of your employees is excluded, immediately inform your Compliance Officer, and notify Ultimate Health Plans.*

Retribution

Ultimate strictly prohibits retaliation against any health care professional, entity or vendor who reports, in good faith, an actual or possible violation of any federal or state law or regulation, policy, or ethical standard.

Reporting Suspected FWA*:*

Ultimate Health Plan, Inc. Confidential 24-Hour Compliance/FWA Hotline
Tel: (855) 730-7925
Email: ComplianceHotline@ulthp.com

You may also contact any State or Federal Agency:
Health and Human Services – Office of Inspector General (HHS-OIG)
Tel: (800) 447-8477
TTY: (800) 377-4950

Medicare Drug Integrity Contractor (MEDIC)
Tel: (877) 772-3379
Florida Department of Financial Services
Tel: (800) 378-0445
Online: https://myfloridacfo.com/fraudfreeflorida/

Florida Attorney General
Tel: (866) 966-7226

The function and activities of Risk Management are to provide the most efficient and effective method for correcting, reducing, or eliminating identifiable risks. The program focus is to protect and conserve the assets, public image, and reputation of the Provider and/or Ultimate from the consequences of risks associated with Members, visitors and employees at the lowest reasonable cost.

The Risk Management process involves the identification, investigation, analysis, evaluation, and prevention of problems, including quality-of-care issues affecting the provision of medical care in order to:

- Enhance the quality-of-care provided to Members.
- Minimize incidents of legal claims against Providers of care and/or Ultimate.
- Maintain Member satisfaction with the Provider and Ultimate.

Incident Reporting

An “Incident Reporting Process” has been implemented to document any incidents associated with any Member, leading to risk that occurred anywhere throughout the health care delivery system. Provider input and participation in the quality improvement process identifies potential risks in the clinical aspects of our Member’s care.

Each Member of the medical care team has an equally important role in minimizing the occurrence of incidents. All healthcare Providers and employees of Ultimate have the obligation to report adverse or untoward incidents and adhere to the protocol for any necessary follow-up.

The primary goal of the incident reporting system is to correct, reduce, modify, or eliminate all identifiable risk situations which could result in claims and litigation for injury or loss; this can be accomplished through:

- On-going educational and training programs in risk management and risk prevention.
- Participation in safety, utilization review, quality assessment and improvement activities.
- Interfacing with the medical staff to ensure communication and cooperation in risk management.
- Exchanging information with professional organizations, peers, and other resources, to improve and update the program.
- Analyzing patient “Incident Reports” for trends and patterns which relate to patient care and the quality of medical services.

Provider’s Office - Risk Management

A Provider’s staff reflects their practice, and they are an important factor in ensuring patient satisfaction. Providers should have a designated Risk Manager for his or her office and develop their own risk management policies and procedures. The Risk Manager’s role is to reduce medical practice risks by implementing and assuring that education and training on these policies are included in an initial orientation for all staff personnel and that a program of education and training, lasting at least an hour, is completed annually by all clinical personnel who provide patient care.

Internal Incident Reporting

The “Internal Incident Reporting Process” is the means for reporting adverse or untoward incidents which occur.

Adverse or untoward incidents are defined as:

- An unexpected occurrence during a health care encounter involving Member death or serious physical/psychological injury or illness. This includes loss of limb or function unrelated to the natural course of the Member's illness or underlying condition.
- Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.
- Events such as breeches in medical care, administrative procedures or other occurrences resulting in a negative impact on a Member, even where death or loss of limb or function does not occur.
- An event in which health care personnel could exercise control; and
    - Is probably associated with medical intervention rather than the condition for which such intervention occurred.
    - Is not consistent with, or expected to be, a consequence of such medical interventions.
    - Occurs because of medical intervention to which the patient has not given his informed consent.
    - Occurs because of any other action, or lack thereof, on the part of the facility or personnel of the facility.
    - Results in a surgical procedure being performed on the wrong patient.
    - Results in a surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries, and procedures to remove foreign objects remaining from surgical procedures.
    - Causes injury to a patient with the following outcomes when caused by an adverse incident:
        a) Death.
        b) Brain damage.
        c) Spinal damage.
        d) Permanent disfigurement.
        e) Fracture or dislocation of bones or joints.
        f) Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the Member's case or Member's pre-existing physical condition.
        g) Any condition requiring surgical intervention to correct or control.
        h) Any condition resulting in transfer of the Member, within or outside the facility, to a unit providing a more acute level of care.
        i) Any condition which extends the Member's length of facility stay.
        j) Any condition which results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.

It is the policy of the Risk Manager to document and report all adverse and untoward incidents (potential and actual) on the incident report form for necessary follow-up.

- The incident reporting system requires all Providers and employees to report injuries and other adverse or untoward incidents to the Risk Manager.
- Employees, Providers and their staff shall be cautioned against exposing the organization to liability by their acts or statements in the presence of Members, visitors or others.
- No health care Provider, agent or employee will be terminated based solely upon an unintentional, non-malicious incident, if reported; however, failure to report an incident will be grounds for disciplinary action or termination.

Reporting Responsibilities

All incidents and adverse events involving Ultimate Members must be reported to the Plan within three (3) calendar days either telephonically or by certified mail. If the incident has resulted in serious or potentially serious patient harm, the Ultimate Risk Manager shall be contacted immediately.

The Providers should contact Ultimate by means of:

- Telephonically between the Physician and/or Practice Risk Manager and the Ultimate Risk Manager and/or the Risk Manager Designee.
- Telephonically between Provider and their assigned Ultimate Account Executive.
- Telephonically between the Physician and the Ultimate Medical Director.
- In writing, via certified mail, by completing a "Member Incident Report", filled out by the attending physician or the Practice Risk Manager. The report should be mailed to the Ultimate Risk Manager or Provider's designated Account Executive. Due to lack of confidentiality, facsimiles should be avoided unless otherwise instructed by Ultimate.

Incident Report Review and Analysis

Incident reports are an "Attorney Record of Incident" and shall be considered privileged and confidential in all regards accordingly. No copies shall be made of any incident report for any reason.

- The Risk Manager will review all incident reports and analyze them for trends and patterns, including the frequency, cause and severity of incidents by location, Provider and type of incident.
- The Risk Manager will have access to all health maintenance organization or Provider medical records.
- The incident reports will be utilized to develop categories of incidents which identify problems.
- Once problems become evident, the Risk Manager will make recommendations for corrective action(s).
- When a definitive injury occurs, cases will be categorized using the ICD-9-CM coding classification.

All information submitted to the health plan which is used to investigate potential quality issues and for risk management review will remain strictly confidential in accordance with the policies and procedures set forth on confidentiality.

*If you have any questions, please contact Provider Relations for assistance.

Exposures to Blood

Health care workers are at risk for occupational exposure to blood-borne pathogens, including hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV). Exposures may occur through needle sticks or cuts from other sharp instruments contaminated with an infected patient's blood or through contact of the eye, nose, mouth, or skin with an infected patient's blood. Important factors which may determine the overall risk for occupational transmission of a blood-borne pathogen include the number of infected individuals in the patient population, the chance of becoming infected after a single blood contact from an infected patient, and the type and number of blood contacts.

Most exposures do not result in infection. After a specific exposure, the risk of infection may vary based upon factors such as these:

- The type of exposure.
- The amount of blood involved in the exposure.
- The pathogen involved.

- The amount of virus in the patient's blood at the time of exposure

Physicians should have a system in place for reporting exposures to quickly evaluate the risk of infection, inform patients about treatments available to prevent infection, monitor patients for side effects and to determine if infection occurs. This may involve blood tests of the patient exposed and the source patient and offering appropriate post-exposure treatment.

Prevention of Occupational Exposure

Many needle sticks and other cuts can be prevented by using safer techniques (for example, not recapping needles by hand, disposing of used needles in appropriate Sharps disposal containers and using medical devices with safety features designed to prevent injuries). Many exposures to the eyes, nose, mouth, or skin can be prevented by using appropriate barriers (for example, gloves, eye and face protection, gowns) when contact with blood is expected.

If an exposure occurs:
Scientific evidence does not show that using antiseptics or squeezing the wound will reduce the risk of transmission of a blood-borne pathogen. Using a caustic agent such as bleach is not recommended.

Immediately following an exposure to blood, the individual should:

- Wash needle sticks and cuts with soap and water.
- Flush the nose, mouth, or skin with water.
- Irrigate eyes with clean water, saline, or sterile irrigates.
- Report the exposure to the department (e.g., occupational health, infection control) responsible for managing exposures. Prompt reporting is essential because in some cases post-exposure treatment may be recommended and it should be initiated as soon as possible.
- Discuss the possible risks of acquiring HBV, HCV and HIV and the need for post exposure treatment and/or recommended follow-up testing and surveillance with the Provider managing the exposure. All persons should have already received Hepatitis B vaccine, which is extremely safe and effective in preventing HBV infection.

The CDC offers free information about occupational exposure to blood-borne pathogens.

You can access the information by visiting the website of the Centers for Disease Control (CDC) CDC's National Institute of Occupational Safety and Health: https://www.cdc.gov/niosh/

Hepatitis B and Hepatitis C

For additional information about HBV and HCV, call the Hepatitis Information Hotline at (888) 4-EPCDC (888-443-7232) or visit the CDC hepatitis website at: https://www.cdc.gov/hepatitis/index.htm .

Any person who believes that they have had an adverse reaction to any vaccine should report this to his/her health care Provider. The Vaccine Adverse Event Reporting System at (800) 822- 7967 receives and documents these types of reports from health care Providers and others reporting vaccine side effects.

Human Immunodeficiency Virus (HIV) & Acquired Immune Deficiency Syndrome (AIDS)

Information and resources regarding HIV infection and AIDS are available on the CDC website: https://www.cdc.gov/hiv/default.html. The HIV/AIDS Treatment Information Service (800.448.0440) can also be contacted for information on the clinical treatment of HIV/AIDS.

Standard Precautions for Infection Control

Standard precautions such as handwashing and using gloves to prevent gross microbial contamination of hands are intended to supplement, rather than replace, recommendations for routine infection control. Since it is impractical to specify all types of barriers for every possible clinical situation, some judgment must be exercised.

The risk of nosocomial transmission of HIV, HBV and other blood-borne pathogens can be minimized if health care workers use the following general guidelines:

- Take care to prevent injuries when using needles, scalpels and other sharp instruments or devices, when handling sharp instruments after procedures, when cleaning used instruments and when disposing of used needles.
- Do not recap used needles by hand; Do not remove used needles from disposable syringes by hand.
- Do not bend, break, or otherwise manipulate used needles by hand.
- Place used disposable syringes, needles, scalpel blades and other sharp items in Sharps containers for disposal.
- Locate the puncture-resistant containers as close to the procedure as possible.
- Use protective barriers to prevent exposure to blood, body fluids containing visible blood and/or other body fluids to which universal precautions apply. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.
- Immediately and thoroughly wash hands and other skin surfaces which are contaminated with blood, body fluids containing visible blood and/or other body fluids to which universal precautions apply.

Glove Use for Phlebotomy

Gloves will reduce the incidence of contamination during phlebotomy (drawing blood samples), but they cannot prevent penetrating injuries caused by needles or other sharp instruments.

The likelihood of hand contamination with blood containing HIV, HBV or other blood-borne pathogens during phlebotomy depends on several factors:

- The skill and technique of the health care worker.
- The frequency with which the health care worker performs the procedure (other factors being equal, the cumulative risk of blood exposure is higher for a health care worker who performs more procedures).
- Whether the procedure occurs in a routine or emergency (where blood contact may be more likely).
- The prevalence of infection with blood-borne pathogens in the patient population.

The likelihood of infection after skin exposure to blood containing HIV or HBV (viral concentration is much higher for hepatitis B than for HIV) will depend upon the concentration of the duration of contact, the presence of skin lesions on the hands of the health care worker, and – for HBV – the immune status of the health care worker. Although not accurately quantified, the risk of HIV infection following intact skin contact with infective blood is less than the 0.5 percent risk following percutaneous needle stick exposures.

In universal precautions, all blood is assumed to be potentially infective for blood-borne pathogens, but in certain settings (e.g., volunteer blood donation centers) the prevalence of infection with some blood-borne pathogens (e.g., HIV, HBV) is known to be very low. Some institutions have relaxed

recommendations for using gloves for phlebotomy procedures by skilled phlebotomists in settings where the prevalence of blood-borne pathogens is known to be very low. It is the recommendation of Ultimate that participating Providers follow OSHA guidelines for the prevention of disease control and wearing gloves during, but not limited to, phlebotomy.

Waste Management

Universal precautions are not intended to change waste management programs previously recommended by the CDC for health care settings. Policies for defining, collecting, storing, decontaminating, and disposing of infective waste are generally determined by institutions in accordance with state and local regulations.

Information regarding waste management regulations in health care settings may be obtained from state or local health departments, or agencies responsible for waste management.

Administrative Fee: The amount subtracted from the total monthly premiums received on behalf of the Member for each line of business (Commercial, Medicaid, Medicare and Long Term Care Diversion Program) which is retained by Ultimate for administrative functions. The amount of the administrative fee is set according to the terms of your Primary Care Provider Agreement.

Admitting Physician: A Provider, or group of Providers, which may include a Hospitalist, Specialist or another Primary Care Provider who may admit Members into the hospital on behalf of the Primary Care Provider.

Agreement: A binding arrangement between Provider and Ultimate.

Benefit Plan: A description of a Member's benefits which are covered under one of Ultimate lines of business.

Calendar Quarter: Every calendar year is divided into the following four parts, known as quarters: First quarter, January 1st through March 31st; second quarter, April 1st through June 30th; third quarter, July 1st; through September 30th and; fourth quarter, October 1st through December 31st.

Capitation: The monthly compensation made to Provider by Ultimate for covered services. The (per Member, per month/PMPM) amount of the capitation fee is set forth in the Provider Agreement.

Claim: An invoice submitted by Provider for services rendered to a Member on a UB-04 (otherwise known as CMS-1450) or HCFA-1500 forms. In addition, this same form may be used to collect encounter data from capitated Providers.

Clean Claims: A claim which has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment which prevents timely payment from being made to the Provider.

Coordination of Benefits: The allocation of financial responsibility between two or more insurers of healthcare services, each with a legal duty to pay or provide covered services to a Member at the same time.

Co-payment: Charges for which the Member is responsible to pay Provider at the time covered services are rendered. The amount of co-payment, if any, is determined in accordance with the Member's benefit plan.

Covered Services: Those services in accordance with federal and state regulatory requirements, and/or the Member's evidence of coverage, for which payment is provided under the terms of the "Provider Agreement" or the prior authorization obtained from Ultimate.

Covering Physician: A participating Provider who has entered an arrangement with another Provider to provide covered services to their Plan Members.

Cultural Competency: The ability to work effectively with colleagues and patients in cross-cultural situations.

Deductible: Fixed amount or percentage of an insurance claim which is the responsibility of the insured (Member), and which Ultimate will deduct from claims reimbursement.

Emergency Medical Condition: A medical condition manifesting itself with acute symptoms of sufficient severity (which may include severe pain or other acute symptoms), such that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the Member or, in the case of a pregnant woman, the health of her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ and or part. With respect to pregnant women:
- That there is inadequate time to effect safe transfer to another hospital prior to delivery.
- That transfer may pose a threat to the health and safety of the Member or fetus.
- That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Services and Care: Medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency service and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Encounter Data: A record of covered services provided to Plan Member. An "encounter" is an interaction between a Member and Provider who delivers services or is professionally responsible for services delivered to Plan Members.

Experimental and/or Investigational: Those services, supplies, care, and treatment which do not constitute accepted medical practice or do not fall within the range of appropriate medical practice under the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered. The following are examples of services, supplies, care, and treatment which are considered experimental and/or investigational:

- if the drug or device cannot be lawfully marketed for the particular diagnosis without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished.
- if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.
- if Reliable Evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

In making the determination that a service, supply, care, or treatment is experimental and/or investigational, reference will be made to Practice Guidelines and coverage policies of Government Agencies such as the Centers for Medicare and Medicaid Services.

Explanation of Benefits (EOB): A statement, explaining which medical services were paid or denied, sent to Member and/or Provider by Ultimate in response to a claim submitted.

Fee for Services: A mutually agreed upon payment structure of reimbursement, to be paid to the Provider by Ultimate for covered services rendered to Plan Members.

Government Agencies: For this Provider Manual, these acronyms will mean as follows:

AHCA: State of Florida Agency for Health Care Administration
CMS: Centers for Medicare and Medicaid Services
DHHS: US Department of Health and Human Services
DCFS: State of Florida Department of Children and Family Services
DOFS: Department of Financial Services
GAO: Government Accounting Office
OIR: State of Florida Office of Insurance Regulation

Grievance Program: Procedures established by Ultimate in accordance with state and federal guidelines to address and resolve Member and Provider grievances in a timely manner.

Hospitalist: A Provider who assumes the care of hospitalized Members in the place of Member's Primary Care Physician. Participating Hospitalists will provide the following services to Plan Members:

- Emergency room assessment of a Member.
- Direct admissions to facilities where the Primary Care Provider may not provide services or has chosen not to provide services under the terms of their agreement.
- Manages care, as needed, throughout the process of the inpatient medical admission for Members; and
- Refer Members to their Primary Care Provider upon discharge for follow-up care and communicates the treatment and discharge plan to PCP and/or Plan.

Medical Group: A group of Primary Care Providers and /or Specialist Physicians who:

- Are formally organized as a partnership or professional corporation.
- Provide for the diagnosis or direct care and treatment of a medical condition.
- May divide their income based upon a specified, fixed formula.
- Medical Information: Clinical information in electronic or hardcopy form in possession of, or derived from, a Provider of health care or health care service plan, pertaining to a Member's medical history, mental or physical condition, or treatment.

Medical Records: Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise.

attested to, as appropriate to the media, and meet the requirements of 42 CFR 456.111 and 42 CFR 456.211.

Medically Necessary: Shall be determined by Ultimate Medical Director and shall include consideration of the following and/or meet the following conditions:

- Be necessary to protect life, prevent significant illness, significant disability or to alleviate severe pain.
- Be individual, specific, and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not more than the patient's needs.
- Be consistent with the generally accepted professional medical standards, as determined by Medicare and not be experimental or investigational.
- Be reflective of the level of service which can be furnished safely and for which not equally effective and more conservative, or less costly treatment, is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker, or the Provider.

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity (except for a Provider-sponsored organization receiving waivers) which is certified by CMS as meeting the Medicare Advantage Contract.

Medicare Advantage Plan: Health benefit coverage offered under a policy or contract by a Medicare Advantage Organization, which includes a specific set of health benefits offered at a uniform premium and uniform level cost-sharing to all Medicare beneficiaries residing in the service areas (or segment of the service areas) of the Medicare Advantage Plan.

Medicare Recipient: Any eligible individual who is entitled to medical and hospital benefits under Title XVIII of the Social Security Act, as amended. Medicare Advantage Prescription Drug Plan (MA-PD Plan): A Medicare Advantage Plan which provides qualified prescription drug coverage under Part D of the Social Security Act.

Member: An individual who is enrolled in an Ultimate benefit plan for the provision of covered services. A Member is also referred to as an enrollee, beneficiary, recipient, or subscriber.

Non-Covered Services: A service which is not a benefit under Medicare or Ultimate benefit plan.

Participating Hospital: A hospital that has entered into a contractual agreement with Ultimate.

Participating Provider: A health care practitioner, or entity, authorized to do business in the state of Florida and who has entered into an agreement with Ultimate to provide medical services to Members.

Participating Specialist: A physician, licensed to practice medicine in the state of Florida, who has entered into an agreement with Ultimate to provide specialized medical services to Members.

Physician Extender: A health care Provider who is not a physician, but who performs medical activities typically performed by a physician, most commonly: A Physician Assistant (PA), Osteopathic Assistant (OA), Advanced Registered Nurse Practitioners (ARNP) or Certified Nurse Midwife (CNM).

Primary Care Provider (PCP): A participating physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, or other specialty approved by the state of Florida, who furnishes primary care and patient management services to Members.

Primary Care: Comprehensive, coordinated and readily accessible medical care including: Health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to a specialist when appropriate.

Provider Manual: A resource of Ultimate policies, procedures, standards, and specific documents, (as may be unilaterally amended or modified from time-to-time by Ultimate) for the use and instruction for Provider, and to which Provider must adhere.

Quality: The degree to which Ultimate increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics and through the provision of health services which are consistent with current professional knowledge.

Quality Enhancements: Certain health-related, community-based services which Ultimate offers and coordinates access to for Members, such as children's programs, domestic violence classes, pregnancy prevention, smoking cessation, or substance abuse programs.

Quality Management Program: The policies, procedures developed by Ultimate for monitoring the delivery of health care services, assessing, and improving the accessibility, timely, and medically necessary health care. Monitoring includes, but is not limited to, the quality and continuity of care provided to Plan Members.

Referral: The process by which a physician directs a Member to seek and obtain covered services from a health professional such as a specialist, ancillary, hospital or any other Provider.

Reserve: An amount set aside which may be referred to as the "Claims Fund" or "Service Fund" estimated by Ultimate to be sufficient to satisfy claims which have been incurred but not reported (IBNR) based upon the historical experience of Members. The reserve amount shall be determined by Ultimate.

Service Area: A geographic area within which Ultimate is authorized and approved by the applicable regulatory agencies to provide covered services to Members.

Sick Care: Non-urgent problems which do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Specialist Services: Those services provided by a specialty physician within the scope of his/her specialty which may be Board-certified, or Board-qualified, and credentialed or otherwise recognized by Ultimate as a specialty Provider, which are: Provided upon with the referral of a Primary Care Provider pursuant to the rules and regulations of Ultimate; (2) And/or with authorization from Ultimate.

Subscriber Agreement: The group or individual agreement under which a member is entitled to receive covered services through Ultimate. Ultimate Health Plans, Inc. (Ultimate): A Florida-based Health Maintenance Organization (HMO) delivering services to Medicare Advantage benefit plan Members.

Urgent Care: Care provided for those conditions which are non-life-threatening, but could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or do substantially restrict a Member's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

Utilization Review and Management Program: The policies, procedures and systems developed by Ultimate for monitoring the utilization of covered services by Members, including, but not limited to, underutilization and overutilization.

Well Care: A routine medical visit for one of the following: Initial and yearly check-ups, family- planning, routine follow-up to a previously treated condition or illness, adult physicals and any other routine visit which is not for the treatment of an illness.

For updated forms, please visit www.chooseultimate.com or contact Provider Relations. The available forms and additional resources are outlined below.

Forms:

- Prior Authorization Request Form
- Prescription Drug Coverage Determination Form. This form can be used for the following:
  - To request prior authorization for prescription drug that requires it.
  - To request prior authorization for a drug designated as a high-risk medication.
  - To request that we cover a non-formulary drug.
  - To request that we waive quantity limit on a drug.
  - To request that a drug be covered at a lower tier.
  - To request that we waive the requirement to try an alternative drug first.
- Member Transfer Request Form
- Participating Provider Dispute Resolution Request Form
- Risk Management – Incident Report Form
- Advanced Healthcare Directives (English/Spanish)
- Case Management Referral Form
- Referral Request Form

Resources:

- Quick Reference Guide (QRG)
- Ultimate Health Plans Authorization Process Overview
- Prior Authorization Exclusion List
- Ultimate Health Plans Member Rights and Responsibilities Statement
- Patient's Bill of Rights and Responsibilities (English/Spanish)
- Consumer Assistance Notice (English/Spanish)

Please note: A copy of the Consumer Assistance Notice and Patient's Bill of Rights and Responsibilities must be visually posted for Members in all practice locations.

BENEFIT	VENDOR	PAPER CLAIMS MAILING ADDRESS/PHONE/WEBSITE
Acupuncture & Chiropractic	**American Specialty Health**	American Specialty Health ATTN: Claims PO Box 509002 San Diego, CA 92150 (888) 577-0055
Behavioral Health	**Carelon Behavioral Health (formerly known as Beacon Health Options)**	Carelon Behavioral Health (formerly known as Beacon Health Options) ATTN: Claims PO Box 1870 Hicksville, NY 11802 (800) 627-1259 https://providersearch.carelonbehavioralhealth.com/#/provider/home/80
Behavioral Health (Telemedicine - MD Live)	**Carelon Behavioral Health (formerly known as Beacon Health Options)**	(855) 849-3650 www.mdlive.com
Dental	**Aflac Benefits Solutions**	Aflac Benefits Solutions ATTN: Claims PO Box 211276 Eagan MN 55121-2776 (800) 340-8869 www.aflacbenefitssolutions.com
Gym Benefit	**Silver Sneakers**	(888) 423-4632 www.silversneakers.com
Hearing	**20/20 Hearing Care**	20/20 Hearing Care Network 2900 W Cypress Creek Rd, Ste 4 Ft. Lauderdale, FL 33309 (800) 313-2763 www.2020hearingnetwork.com/
In-Home Support (Companionship, Everyday Tasks & Transportation)	**Papa Pals**	(800) 348-7951
Laboratory Services	**LabCorp**	(800) 845-6167 www.labcorp.com
Meal Delivery (Post discharge nutrition)	**Mom's Meals**	Ultimate Member Services (888) 657-4170
Nurse Hotline - 24/7	**Carenet Health**	(855) 238-4687
Over-the-Counter (OTC) Benefits, Healthy Food & Flex Cards	**Solutran**	(855) 422-0039 www.healthybenefitsplus.com/chooseultimate
Prescription Drug Benefit - 24/7	**OptumRx**	(800) 311-7517 www.optumrx.com/members
Prescription Mail Order	**OptumRx**	(877) 889-6358
Transportation	**Wheelchair Transport Service (WTS)**	(855) 306-0700
Vision - Routine Vision & Medical Eye Care (For services prior to 1/1/2023)	**Aflac Benefits Solutions**	Aflac Benefits Solutions ATTN: Claims PO Box 211276 Eagan MN 55121-2776 (800) 340-8869 www.aflacbenefitssolutions.com
Vision - Routine Vision & Medical Eye Care (For services on or after 1/1/2023)	**Premier Eye Care**	Premier Eye Care ATTN: Claims 6501 Park of Commerce Blvd, First Floor Boca Raton, FL 33487 (800) 210-5511 https://providerdirectory.premiereyecare.net/