2026 Turquoise Care Provider Manual

Physician, Care Provider, Facility, and Ancillary

New Mexico

Doc#: PMG 20260120-085538

United Healthcare® Community Plan

a product of United Healthcare Insurance Company

Welcome

Welcome to the UnitedHealthcare Community Plan® care provider manual. This up-to-date reference PDF manual allows you and your staff to find important information, such as how to process a claim and submit prior authorization requests for your UnitedHealthcare Turquoise Care members. It features important phone numbers and websites in the How to Contact Us section.

Click to access different care provider manuals

- **Administrative Guide** – **UHCprovider.com/guides**
  Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan care provider manual** – **UHCprovider.com/guides**
  Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Find Your State/ New Mexico**.

View the **Medicaid glossary** for definitions of terms commonly used throughout the care providers manuals.

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-888-702-2202.**

Find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

Using this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this care provider manual, unless your Agreement states you should use the Agreement, instead.

If there is a conflict between your Agreement, this care provider manual and applicable federal and state statutes and regulations and/or state contracts, the latter will control.

UnitedHealthcare Community Plan reserves the right to supplement this care provider manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Participation Agreement

Terms and definitions as used in this care provider manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- "You," "your" or "care provider" refers to any health care provider subject to this manual, including physicians, clinicians, facilities and ancillary care providers, except when indicated
- "Community Plan" refers to the UnitedHealthcare Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this care provider manual
- Any reference to "ID card" includes a physical or digital card

Thank you for your participation in our program and the care you offer our members.

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Fraud, waste, and abuse	**uhc.com/fraud**	**1-844-359-7736**
Member Services	**uhc.com/communityplan/new-mexico**	**1-877-236-0826**
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-888-702-2202**
Training	**UHCprovider.com/training**	
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal**. New users: **UHCprovider.com/access**	
CommunityCare Provider Portal training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
One Healthcare ID support (formerly known as Optum support)	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	**1-855-819-5909**
Resource library	**UHCprovider.com/resourcelibrary**	

UnitedHealthcare Community Plan supports the New Mexico state goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following members:

- Children, from birth through 18 years old, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act
- Pregnant members eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act
- Children eligible for the Children's Health Insurance Program (CHIP)
- Blind and disabled children and adults who are not eligible for Medicare
- People 19–64 years old who are not eligible for another type of Medicaid and who have an income of less than 138% of the federal poverty level
- Medicaid-eligible families

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com**, or call **Provider Services** at **1-888-702-2202.**

How to join our network

Learn how to join the UnitedHealthcare Community Plan care provider network at **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information.

Already in network and need to make a change?

To change an address or phone number, add or remove physicians from your TIN, or make other changes, go to My Practice Profile at **UHCprovider.com/attestation**.

Approach to health care

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Turquoise Care, care providers and our community to improve care coordination and elevate outcomes.

Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care services, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns and then provides interventions to help members get the right care.

These interventions address members' specific needs, resulting in better quality of life, improved access to health care and reduced expenses.

Care Model provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. Care Model provides:

- Medical, behavioral and social care management using community resources
- An extended care team, including a primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance making and coordinating appointments. The clinical health advocate (CHA) refers members to an RN, behavioral health advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions
- Tools for helping members engage with care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames
- Identify and discuss behavioral health needs, measured by number of behavioral health care provider visits within identified time frames
- Improve pharmacy access
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics
- Empower the member to manage their complex/chronic illness or problem and care transitions
- Improve coordination of care through dedicated staff resources and to meet unique needs
- Engage community care and provider networks to help ensure access to affordable care and the appropriate use of services

To refer a UnitedHealthcare Community Plan member to the Care Model program, call **Member Services** at **1-877-236-0826,** TTY **711**. You may also call **Provider Services** at **1-888-702-2202.**

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support our Cultural Competency Program. For more information, go to **UHCprovider.com/resourcelibrary**> Health Equity Resources > **Cultural Competency**.

- **Cultural competency training and education**

  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources. Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

- **Translation/interpretation/auxiliary aide and services**

  You must provide language services and auxiliary aide and services, including, but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services.

  If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the member.

  Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.

  Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability.

  If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing so they receive them prior to the Virtual Visit.

- **Care for members who are deaf or hard of hearing**

  You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members who are deaf or hard of hearing.

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide interpreter services Monday–Friday, 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call **1-877-842-3210,** TTY **711**
- **I Speak language assistance card**

  This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members
- **Materials for limited English-speaking members**

  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

For more information, go to **uhc.com** > **Language Assistance**.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster.

Learn the differences by viewing the **digital solutions comparison guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically.

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast and efficient — and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

Application Programming Interface

Application Programming Interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer.

This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit **UHCprovider.com/api**.

Electronic data interchange

Electronic data interchange (EDI) is an online resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is that it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging in to different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions. It makes it possible to:

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - Claims (837)
  - Eligibility and benefits (270/271)
  - Claims status (276/277)
  - Referrals and authorizations (278)
  - **EDI 275 Unsolicited Attachment**
  - Hospital admission notifications (278N)
  - Electronic remittance advice (ERA/835)

Visit **UHCprovider.com/edi** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeedi.**

Getting started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system
- Contact clearinghouses to review which electronic transactions can interact with your software system

Read our **Clearinghouse Options** page for more information.

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically.

Point of Care Assist® integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca**.

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information — all at no cost without calling.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- If you need to set up an account on the portal, follow **these steps** to register

Here are the most frequently used tools on the **UnitedHealthcare Provider Portal**:

- **Eligibility and benefits**

  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.

- **Claims**

  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.

- **Prior authorization and notification**

  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.

- **Specialty pharmacy transactions**

  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.

- **My Practice Profile**

  View and update the provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.

- **Document Library**

  Access claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

  See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal can replace letters, faxes, phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process
- Create a transparent view between you and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution time frames
- Run real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

All users will access Direct Connect using the **UnitedHealthcare Provider Portal**.

Email **directconnectsupport@optum.com** to get started with Direct Connect.

Privileges

To help members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable network facilities or arrangements with a network care provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

Provider Services

Provider Services is the primary contact for care providers who need help. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.

They can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more. Provider Services works closely with all departments in UnitedHealthcare Community Plan.

Autodialer, artificial or pre-recorded voice technology

You consent to UnitedHealthcare and its affiliates calling the phone number(s) you provided using an auto-dialer and/or artificial or prerecorded voice technology. To opt out of these outreaches, submit the **Telephone Consumer Protection Act (TCPA) Opt Out form**. The Provider TCPA Opt Out will be processed within 10 business days and registered until such time that the phone number is opted back in for such communications. Should you decide to opt back into receiving such outreaches after opting out, submit the **TCPA Provider Opt In form** and it will be processed within 10 business days and your phone number will be removed from the do not call registry.

For additional TCPA Opt Out assistance, please contact Provider Services. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

How to contact us

*We no longer use fax numbers.

Topic	Contact	Information
Behavioral, mental health and substance abuse	Optum® **providerexpress.com** **1-877-614-0484**	Review eligibility, claims, benefits, authorization and appeals. Refer members for Optum behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-888-702-2202**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT® code list and more information.
Care Model (care management/disease management)	**nmcaremanagement@uhc.com**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Chiropractor care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	
Claims	**UHCprovider.com/claims** **1-888-702-2202** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 31348 Salt Lake City, UT 84131 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 709 Grant Avenue, North Lobby Lake Katrine, NY 12249	Verify a claim status or get information about proper completion or submission of claims.

Topic	Contact	Information
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal **1-888-702-2202** Mailing address: **UnitedHealthcare Community Plan** Attn: Recovery Services P.O. Box 31348 Salt Lake City, UT 84131	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.
Electronic Data Intake (EDI) issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Eligibility	**UHCprovider.com/eligibility** **1-888-702-2202**	Confirm member eligibility.
Enterprise Voice Portal	**1-888-702-2202**	The Enterprise Voice Portal provides self-service functionality. Or call to speak with a contact center agent.
Fraud, waste and abuse (payment integrity)	Payment Integrity Information: **UHCprovider.com/nmcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-844-359-7736** or **1-877-401-9430**	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network**	The Preferred Lab Network webpage provides a full listing of eligible labs.
Medicaid Health Care Authority (HCA)	nmmedicaid.gov 1-800-283-4465	Contact Medicaid directly.
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-888-702-2202**	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com®** **1-877-236-0826**/TTY **711** for help accessing member account	Helps members with issues or concerns. Available Monday-Friday, 7 a.m.– 7 p.m. CT.

Topic	Contact	Information
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	**1-888-702-2202** TDD **711**	Available Monday-Friday, 8 a.m.– 5 p.m. CT, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management support	Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality for medical network care providers to update or check credentialing information.
UnitedHealthcare NurseLine	**1-833-890-3050**	Available 24 hours a day, 7 days a week
Obstetrics/pregnancy and baby care	Healthy First Steps® Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the UnitedHealthcare Provider Portal. **1-800-599-5985** **uhchealthyfirststeps.com**	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards.
Oncology prior authorization	**UHCprovider.com/oncology** Optum **1-888-397-8129** Monday–Friday, 7 a.m.– 7 p.m. CT	For current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat, with a live advocate, is available 7 a.m.- 7 p.m. CT at **UHCprovider.com/chat**. **1-855-819-5909**	Contact if you have issues with your ID. Available Monday-Friday, 7 a.m.– 9 p.m. CT, Saturday, 6 a.m.– 6 p.m. CT, Sunday, 9 a.m.– 6 p.m. CT.
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952**	Optum Rx® oversees and manages our network pharmacies.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826**	Request authorization for medications as required. Use the UnitedHealthcare Provider Portal to access the **PreCheck MyScript® tool**. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.

Topic	Contact	Information
Prior authorization requests/advanced and admission notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N **UHCprovider.com/priorauth** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications," or call **1-888-702-2202**	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments • Check request status Information and advance notification/prior authorization lists: **UHCprovider.com/nmcommunityplan** > Prior Authorization and Notifications
Provider Services	**UHCprovider.com/nmcommunityplan** **1-888-702-2202**	Available Monday-Friday, 8 a.m.– 5 p.m. MT.
Radiology prior authorization	**UHCprovider.com/radiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Referrals	**UHCprovider.com/referrals** Provider Services **1-888-702-2202**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/nmcommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical support	For chat options and contact information, visit **UHCprovider.com/contactus.** **1-866-209-9320** for Optum support	Call if you have issues logging in to the **UnitedHealthcare Provider Portal**, you cannot submit a form, etc.
Tobacco Free Quit Now	1-800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	Member Services **1-877-236-0826** TTY **711** for help accessing member account	To arrange non-emergent transportation, please contact **Member Services** Monday-Friday, 8 a.m.–5 p.m. MT, at least 3 business days in advance.

Topic	Contact	Information
Utilization management	Provider Services **1-888-702-2202**	UM helps avoid overuse and underuse of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to **UHCprovider.com/protocols.** Request a copy of our UM guidelines or information about the program.
Vision services – MARCH® Vision Care	1-844-706-2724	Contact MARCH® Vision Care for information on benefits, lab order submissions and demographic changes.
Website for New Mexico Community Plan	**UHCprovider.com/nmcommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-888-702-2202**
General provider assistance		
Eligibility	**UHCprovider.com/eligibility**	
Referrals	**UHCprovider.com/referrals**	
Provider Directory	**UHCprovider.com/findprovider**	

General care provider responsibilities

Nondiscrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on:

- Age
- Sex
- Race
- Physical
- Disability
- National origin
- Religion
- Type of illness or condition

You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members or patients, or with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs.

Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

UnitedHealthcare Community Plan members and/or their representatives may take part in the planning and implementation of their care. To help ensure members and/or their representatives have this chance, UnitedHealthcare Community Plan requires you to:

1. Educate them and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize they have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care coordinator in developing a specific care plan for members enrolled in high-risk care management.

Provide official notice

Write to us within 10 calendar days when you are no longer willing or able to provide services to a member to include, but not limited to, if any of the following events happen:

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This includes cooperation with the member's Care Coordinator to facilitate a seamless transition. If you are no longer willing or able to provide services to a member due to:

- Caregiver shortage
- Member difficulties such as threatening or verbally abusing caregiver and provider staff

Provider will reach out to assigned Care Coordinator or **UHC_Care.Coordination@uhc.com**. Please provide details of what the provider has attempted to do to work with member and end results.

When transfer is approved, Care Coordinator will work with member on transitioning. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan health care professionals.

For the most current list of network professionals, review our Provider Directory at **UHCprovider.com/findprovider**.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need to take care of their health. To accurately list care providers who treat UnitedHealthcare Community Plan members, we have the right to and may:

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for 1 year and have voluntarily stopped participation in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for 1 year. This is not a termination of the Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a care provider

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Updating your practice or facility information

You can update your practice information through the UnitedHealthcare Provider Portal on **UHCprovider.com**. Go to **UHCprovider.com**, then Sign In > My Practice Profile. Or submit your change by:

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data electronically
- Connecting with us through chat 24/7 in the **UnitedHealthcare Provider Portal**

After-hours care

Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu. If a member calls you after hours asking about urgent care, and you can't fit them into your schedule, refer them to an urgent care center. If the member is in a life-threatening situation, refer them to the ER.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures. UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by the state's government agencies and professional specialty societies. See **Chapter 10** for more details on the initiatives.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

You must allow the plan to use care provider performance data.

Comply with protocols

You must comply with the UnitedHealthcare Community Plan and payer's protocols, including those contained in this care provider manual. You may view protocols at **UHCprovider.com/protocols**.

Background checks

All participating care providers undergo a careful review of their qualifications, including education, training, board certification status, license status, work history, hospital privileges and malpractice sanction history.

Background checks include procedures for verifying the inclusion of care providers on federal and state databases including but not limited to the Office of Inspector General List of Excluded Individuals/Entities (LEIE), General Service Administration System for Awards Management (SAM), National Plan and Provider Enumeration System (NPPES), National Practitioner Data Bank (NPDB) and State Licensing Board.

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. The safeguards include shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference **Chapter 9** for medical record standards.

Member abuse and neglect

Care providers are responsible for reporting any identified or surmised member abuse, neglect or exploitation to the appropriate authorities:

- Adult Protective Services: 1-866-654-3219
- Children, Youth and Families Department: 1-800-797-3260
- Department of Health/Division of Health Improvement (DOH/DHI): 1-800-445-6242

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state laws about advance treatment directives, members' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through member handbooks and other communications.

Your Agreement

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will investigate your grievance. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement.

After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the grievance through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held. If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the member handbook at **UHCprovider.com/nmcommunityplan.**

Also reference **Chapter 12** of this manual for information on care provider claim reconsiderations, appeals and grievances.

Care provider rights

Care providers have the right to deny counseling or referral services based on moral or religious grounds.

Mutual obligations - UnitedHealthcare and care provider professional conduct

Professional conduct

When we conduct business together, you will work with us to ensure that your employees, agents, and any personnel operating in our facilities or yours comply with the following:

- **Collaborate for member outcomes**: Work collaboratively to achieve the best outcomes for members, including coordinating care and sharing necessary information.
- **Respect and professionalism**: At all times, treat other providers, UnitedHealthcare members, and UnitedHealthcare and your employees with respect and professionalism.
- **Prohibit threats and harassment**: Create a safe and respectful environment. Any form of threats, harassment, or intimidation is strictly prohibited, including verbal, physical, and written forms.
- **Prohibit violence**: Prohibit acts of violence against other providers, UnitedHealthcare members, and UnitedHealthcare and your employees.
- **Protect confidential employee information**: Not publicly disclose any confidential personal information about UnitedHealth Group's or your employees, including home address, personal telephone numbers, personal and professional email addresses, medical, or employment-related details, to any third party without express written consent from the other party, unless legally required to do so.

- **Inaccurate statements**: Not make any misleading, inaccurate or untrue statements, whether oral or written, that disparage or intentionally harm the reputation or safety of the other party, its affiliates, or its employees. This includes statements made on social media, in public forums, or any other medium of communication.

If the requirements above are not met, we will collaborate and fully cooperate to address the matters.

If you fail to fully cooperate with UnitedHealthcare to address any violation of these requirements, such conduct is a material breach under the Agreement. UnitedHealthcare may:

- Refuse to interact with any individual engaging in such conduct;
- Terminate any professional's participation in UnitedHealthcare's network, without terminating the Agreement between the parties;
- Terminate the Agreement between the parties upon 30 days' prior written notice; and
- Any other remedies available to the parties under the participation agreement or at law.

Any threat, attempted violence, or acts of violence will be reported to the appropriate authorities including, but not limited to, UnitedHealth Group Corporate Security, appropriate provider security, law enforcement, state and federal regulatory bodies

Appointment standards (New Mexico Health Care Authority access and availability standards)

Comply with the following New Mexico Health Care Authority (HCA) appointment availability standards:

Primary care

PCPs should arrange appointments for:

- Emergency care – immediately or referred to an emergency facility
- Urgent care appointment – within 24 hours
- Routine care appointment – within 30 calendar days
- Physical exam – within 180 calendar days
- Symptomatic non-urgent appointment - within 14 calendar days
- EPSDT appointments – within 6 weeks
- New member appointment – within 30 calendar days

In addition, PCPs must adhere to the following standards:

- After-hours care phone number – 24 hours, 7 days a week
- In-office waiting for appointments – not to exceed 1 hour of the scheduled appointment time

Specialty care

Specialists should arrange appointments for routine appointments within 30 working days of request/referral.

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- Urgent - within 24 hours
- First and second trimester – within 7 calendar days of request
- Third trimester – within 3 days of request
- High-risk – within 3 calendar days of identification of high risk

UnitedHealthcare Community Plan periodically conducts surveys to check appointment availability and access standards. All care providers must participate in all activities related to these surveys

Health Information Exchange participation

UnitedHealthcare encourages all contracted New Mexico providers to participate in SYNCRONYS, the designated Health Information Exchange (HIE). The solution offers clinical portal access, longitudinal patient records, advanced directives and form registries, access to prescription drug monitoring, along with high-value use cases and insights. The organization is recognized by the New Mexico Department of Health as its agent for public health reporting.

Provider Directory

You are required to tell us, within 5 business days, if you can no longer accept new patients to prevent any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional help finding a care provider.

We are required to contact all participating care providers annually and independent physicians every 6 months. We require you to confirm your information is accurate or provide us with applicable changes.

We allow you up to 45 business days to contact us. If you don't, we notify you that if you continue to be nonresponsive, we will remove you from our directory after 10 business days.

If we receive notification the information is inaccurate, you may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we reach out if we receive a report of incorrect care provider information. We are required to confirm your information.

To help ensure we have your most current information:

- **Delegated care providers** – submit changes to your designated submission pathway
- **Nondelegated care providers** – visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data

Find the medical, dental and mental health care provider directory at **UHCprovider.com/findprovider**.

Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-888-702-2202.** If you have received the upgraded My Practice Profile and have editing rights, access the UnitedHealthcare Provider Portal for My Practice Profile to make many of the updates required in this section.

When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

Prior authorization is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services and/or medication.

Coverage may only be provided if the service or medication is deemed medically necessary or meets specific requirements provided in the benefit plan.

Take the following steps before providing medical services and/or medication to UnitedHealthcare Community Plan members:

- Verify UnitedHealthcare Turquoise Care eligibility using the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-888-702-2202.** Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization from the **UnitedHealthcare Provider Portal:**
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then Sign In.
  2. Select the **Prior Authorization and Notification app.**
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- **Urgent** – 24 hours
- **Nonurgent** – 10 business days

Requirements for primary care providers and specialists serving in primary care provider role

Specialties include internal medicine, pediatrics or obstetrics/gynecology

PCPs are an important partner in the delivery of care, and New Mexico Health Care Authority (HCA) members may seek services from any participating care provider. The New Mexico Health Care Authority (HCA) program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

Medical doctors (M.D.s), doctors of osteopathy (D.O.s), nurse practitioners (N.P.s) and physician assistants (P.A.s) from any of the following practice areas can be PCPs:

- General practice
- Internal medicine
- Family practice
- Pediatrics
- Obstetrics/gynecology

N.P.s may enroll with the state as solo care providers, but P.A.s cannot. P.A.s must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services**.

Customer service is available Monday-Friday, 7 a.m.– 7 p.m. ET.

We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Members have direct access (without a referral or authorization) to any OB/GYNs, midwives, P.A.s, or N.P.s for women's health care services and any nonwomen's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support and benefit from the primary care case management system. This includes PCP availability of 24 hours a day, 7 days a week.

During nonoffice hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for nonemergency services. **Recorded messages are not acceptable.**

Consult with other appropriate care providers to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan to identify members who may need preventive health procedures or testing
- Submit all accurately coded claims or encounters in a timely manner
- Provide all well-baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1-M.D. practice and at least 30 hours per week for a 2-or-more-M.D. practice
- Be available to members by telephone at any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Responsibilities of primary care providers and specialists serving in primary care provider role

Specialties include internal medicine, pediatrics or obstetrics/gynecology

In addition to meeting the requirements for all care providers, PCPs must:

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for Appointment Scheduling section of this manual
- Conduct a baseline exam during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services, UnitedHealthcare Community Plan Clinical or Pharmacy departments as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.

- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care based on UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and
- Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Complying with the New Mexico Health Care Authority (HCA) Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment standards are covered in this chapter.

Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services**
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

Rural health clinic, federally qualified health clinic and primary care clinic

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a rural health clinic (RHC), federally qualified health center (FQHC) or primary care clinic (PCC) as their PCP.

- **RHC**
  The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **FQHC**
  An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a P.A., N.P., social worker and/or another care provider
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits
- **PCC**
  A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a PCC that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

In addition to applicable requirements for all care providers, specialists must:

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services

- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the New Mexico Health Care Authority (HCA) Access and Availability standards for scheduling routine visits. Appointment standards are covered in this chapter.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Ancillary care provider responsibilities

Ancillary care providers include:

- Freestanding radiology and clinical labs
- Home health
- Hospice
- Dialysis
- Durable medical equipment
- Infusion care
- Therapy
- Ambulatory surgery centers
- Freestanding sleep centers
- Other non-care providers

PCPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

UnitedHealthcare Community Plan participating ancillary providers should maintain sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services**
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Identify and bill other insurance carriers when appropriate. Interacting with capitated/delegated groups

Interacting with capitated/ delegated groups

In your market, you may work with entities that have capitated or delegated arrangements with UnitedHealthcare ("capitated organization"). If your patient is assigned to one of these capitated organizations, specific utilization management or claims processing rules may apply.

What is capitation?

Capitation is a payment model in which providers receive a fixed per-member, per-period payment, regardless of services rendered. Common capitated entities include Independent Practice Associations (IPAs), medical groups, and occasionally hospital systems or ancillary care providers.

What is delegation?

Delegation is the transfer of authority to perform specific functions on our behalf.

We may delegate:

- Medical management
- Credentialing
- Utilization management

- Claims processing and payment
- Complex case management
- Other clinical and administrative functions

When responsibilities are delegated to a care provider, they become a "delegated entity" or "delegate." UnitedHealthcare retains accountability to regulators for all delegated activities.

Delegated entities may contract with other care providers, but those agreements must follow UnitedHealthcare's product-specific regulations. To obtain and maintain delegation, care providers must comply with our standards and best practices. Non-compliance may result in revocation of delegated responsibilities.

Capitated organizations are often also delegated entities, making them responsible for both delivering care and administering delegated functions, such as processing and paying claims for other care providers.

What does it mean for you if you are not a capitated/delegated care provider?

You may enter into direct agreements with capitated or delegated organizations. These agreements may differ from your Participation Agreement with UnitedHealthcare and should clearly define applicable protocols and procedures.

Key principles:

- **If you participate with both UnitedHealthcare and a capitated organization, and provide designated covered services to a capitated member:** The capitated organization is solely responsible for payment, based on your agreement with them.
- **If you participate with UnitedHealthcare but not with the capitated organization, and provide designated covered services to a capitated member:** The capitated organization remains solely responsible for payment. Reimbursement follows your UnitedHealthcare Participation Agreement.
- **If you participate with both UnitedHealthcare and a capitated organization, and provide services to a non-capitated member:** UnitedHealthcare (or the financially responsible entity) is solely responsible for payment, per your UnitedHealthcare Participation Agreement.

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com/nm**	**1-877-236-0826**
Member handbook	**UHCCommunityPlan.com/nm** > Plan Details > Member Resources > View Available Resources	
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-888-702-2202**
Prior authorization	**UHCprovider.com/priorauth**	
D-SNP	**UHCprovider.com/nm** > Medicare > Dual Complete Special Needs Plan	**1-866-393-0208**

Benefits

Go to **UHCCommunityPlan.com/nm** or **UHCprovider.com/eligibility** for more information.

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the Provider Portal at **UHCprovider.com** then Sign In. Each month, we monitor PCP panel sizes via PCP-to-member ratio reports. When a PCP's panel nears the max limit, we remove it from auto-assignment.

1. Go to **UHCprovider.com**.
2. Select Sign In on the top right.
3. Log in.
4. Select Clinical & Pharmacy tab.
5. Select UnitedHealthcare Community Care.

The Community Care Roster has member contact information, clinical information to include HEDIS® measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level.

You may also use Document Library for member contact information in a PDF at the individual practitioner level.

You may also use **Report Center** for member contact information in a PDF at the individual practitioner level.

View the **Report Center Interactive User Guide** to see the basic steps you'll take to access letters and secure reports.

Choosing a primary care provider

Each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PCP. The assignment considers the distance to the PCP, the PCP's capacity and if the PCP is accepting new members. UnitedHealthcare Community Plan will assign members to the closest and appropriate PCP.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as:

- Family practice
- General practice
- Internal medicine
- Pediatrics
- Obstetrics

If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Deductibles/copayments

Deductibles and copayments are waived for covered services.

COVID-19 vaccines

To receive free supplies of the COVID-19 vaccine(s), pharmacies, retail clinics and providers planning on administering COVID-19 vaccines must sign an agreement with the U.S. government and adhere to storage and record keeping requirements, including recording the administration of the vaccine to patients in their systems within 24 hours, and to public health data systems as soon as practical and within 72 hours. COVID-19 vaccines are covered regardless of whether the vaccine is delivered by an in-network or out-of-network care provider. Care providers will need to request access to the New Mexico Department of Health (NM DOH) Vaccine Provider Portal to meet the CMS requirements.

Information and access to the NM DOH Vaccine Provider Portal is located at: cv.nmhealth.org/providers/vaccines.

Please see the link below for CDC requirements:

cdc.gov/vaccines/covid-19/vaccination-provider-support.html

See a post from NMDOH on COVID-19 updates at: cv.nmhealth.org.

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services. Medically necessary health care services or supplies are:

- Medically appropriate
- Necessary to meet members' basic health needs
- Cost-efficient and appropriate for the covered services

Member assignment

Assignment to UnitedHealthcare Community Plan

New Mexico Health Care Authority (HCA) assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. New Mexico Health Care Authority (HCA) makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end but may occur mid-month.

At enrollment time, each Turquoise Care member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan member handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the member handbook online by contacting **UHCCommunityPlan.com/nm** > Go to Plan Details > Member Resources > View Available Resources.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members, including newborns, may change from fee-for-service (FFS) to Medicaid Managed Care during hospitalization. To avoid delays in claims processing and payment, check the payer assignment of newborns daily.

Get eligibility information by calling **Provider Services** at **1-888-702-2202**.

Unborn enrollment changes

Encourage your members to notify the New Mexico Health Care Authority (HCA) when they know they are expecting. New Mexico Health Care Authority (HCA) notifies managed care organizations (MCOs) daily of an unborn when New Mexico Medicaid learns a member associated with the MCO is expecting. The MCO or you may use the online change report through the New Mexico website to report the baby's birth. With that information, Health Care Authority (HCA) verifies the birth through the member. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the member should notify Health Care Authority (HCA) when the baby is born.

Members may call the state of New Mexico.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the member has enrolled their baby in a managed care plan.

Primary care provider selection

Although unborn children cannot be enrolled with an MCO until birth, ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections. UnitedHealthcare Community Plan Members can go to **myuhc.com/communityplan** to look up a care provider.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with New Mexico Health Care Authority (HCA), New Mexico's Medicaid program. The New Mexico Health Care Authority (HCA) determines program eligibility. An individual who becomes eligible for the New Mexico Health Care Authority (HCA) program either chooses or is assigned to one of the New Mexico HCA-contracted health plans.

Member ID card

Check the member's ID card at each visit and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice. Possession of a member ID card is not a guarantee of eligibility. Use one of the below methods to verify member eligibility on the date of service.
If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** to report it, or call the Fraud, waste, and abuse hotline**.**

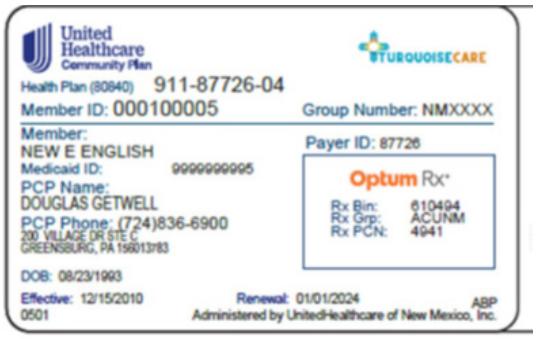
The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

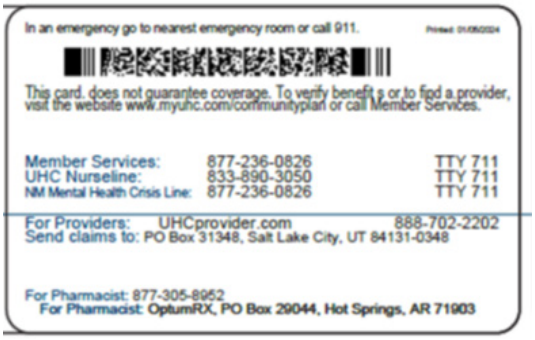
Member identification numbers

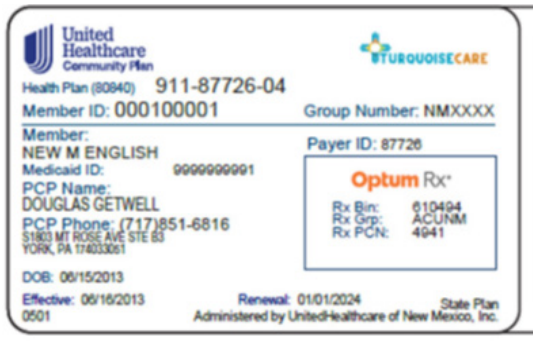
Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use

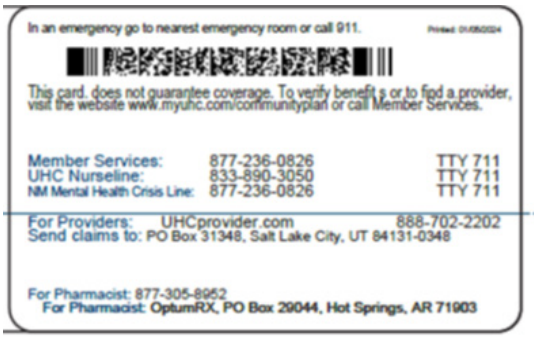
this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The New Mexico Health Care Authority (HCA) Medicaid Number is also on the member ID card.

Sample health member ID cards









Primary care provider initiated transfers

A PCP may transfer a UnitedHealthcare Community Plan member due to an inability to start or maintain a professional relationship or if the member is noncompliant. The PCP must provide care for the member until a transfer is complete.

1. To transfer the member, complete the online form at **UHCCommunityPlan.com/nm**, call the **Member Services** number **1-877-236-0826** on the back of the member's card, or mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

   Mailing address:
   UnitedHealthcare Community Plan
   P.O. Box 31364
   Salt Lake City, UT 84131-0364
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have 5 business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Verifying member enrollment

Verify member eligibility prior to providing services. Determine eligibility in the following ways:

- Access the UnitedHealthcare Provider Portal through **UHCprovider.com/eligibility**
- UnitedHealthcare Provider Services is available from Monday-Friday, 7 a.m.– 5 p.m. CT
- New Mexico Medicaid Eligibility System (MES)

Alternative benefit plan members

UnitedHealthcare Community Plan offers an alternative benefit plan (ABP) for members as a result of the Affordable Care Act Expansion. ABP members have similar, but different benefits than standard Turquoise Care Medicaid members (also known as "ABP-exempt" members).

For example, ABP members are not eligible for long-term services. ABP-exempt members are able to choose ABP instead of their traditional Turquoise Care Medicaid benefits if they choose.

Benefits available to ABP members are listed in **Appendix 1.**

Community benefits

Members may be eligible for Home- and Community-Based Services (HCBS) if they meet certain Medicaid requirements based on medical need. To find out if members are eligible, a care coordinator will assess their level of care. Members will be eligible if the assessment shows they need a certain level of care. Those who are eligible for the Community Benefit have options. They can choose either the Agency-Based or the Self-Directed Community Benefit.

Agency-based community benefit

This option means an agency handles a member's personal care. For example, a personal care agency will help find caregivers who can best meet member needs. The agency will hire the caregivers and do background checks. Members need to work with their care coordinator to coordinate care. The type of care is based on the comprehensive needs assessment. Coverage details included in **Exhibit B.**

Self-directed community benefit

Self-direction is a tool that leads to self-determination, through which members can have greater control over their lives and have more freedom to lead a meaningful life in the community. Within the context of SDCB, self-direction means members choose which covered services they need, as identified in the most recent Comprehensive Needs Assessment (CNA).

SDCB members also decide when, where and how those SDCB covered services will be provided and who they want to provide them. SDCB members decide who they want to assist them with planning and managing their SDCB-covered services within a managed care environment. Self-direction means that SDCB members have more choice, control, flexibility, freedom and responsibility in directing their community benefits. Coverage details included in **Exhibit C**.

UnitedHealthcare Dual Complete

Dual Complete Special Needs Plans (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about D-SNP, go to **uhc.com/medicaid/dsnp**.

For information about D-SNP, please see the Medicare Products chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. For state-specific information, go to **UHCprovider.com/nm** > Medicare > **Dual Complete Special Needs Plans**.

Children in state custody

Native American Children in State Custody (CISC) members may elect to enroll in the UnitedHealthcare Community Plan. All non-Native American Turquoise Care CISC Members are enrolled in the Presbyterian Health Plan.

Native American CISC members will have a dedicated care coordination team led by a registered nurse (RN). Providers who treat Native American CISC members are subject to additional medication prescribing monitoring. Providers may also be subject to additional trainings as required by HCA. Non-network providers who are actively treating Native American CISC members prior to their enrollment with UnitedHealthcare Community Plan will be offered a Provider Agreement or a Single Case Agreement.

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-888-702-2202**
Prior authorization	**UHCprovider.com/priorauth**	
Pharmacy	**professionals.optumrx.com**	**1-877-610-9785**
Dental	**UHCdental.com**	**1-888-445-9817**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**

Medical management improves the quality and outcome of health care delivery. We offer the following services as part of our medical management process.

Ambulance services

Air ambulance

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:

- Great distances or other obstacles keep members from reaching the destination
- Immediate admission is essential
- The pickup point is inaccessible by land

Nonemergent air ambulance requires prior authorization. For authorization, go to **UHCprovider.com/priorauth** or call Provider Services.

Emergency ambulance transportation

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:

- Injury to their overall health
- Impairment to bodily functions
- Dysfunction of a bodily organ or part

Emergency transports (in- and out-of-network) are covered. They do not require an authorization.

Bill ambulance transport as a nonemergency transport when it doesn't meet the definition of an emergency transport. This includes all scheduled runs and transports to nursing facilities or the member's residence.

Nonemergent stretcher/ambulance requests are accepted between 8 a.m. - 5 p.m.

Nonemergency medical transportation

Nonemergency medical transportation (NEMT) services are provided by taxi, van, bus or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity.

NEMT requests are accepted between 8 a.m. and 5 p.m. Members or care providers must call at least 3 days in advance in order to schedule a ride. Call member services at **1-877-236-0826**.

Cardiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for cardiology procedures.

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures
- Stress echocardiograms

Cardiology procedures do not require prior authorization if performed in the following places of service:

- Emergency rooms
- Hospital observation units
- Urgent care centers
- Inpatient settings

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone:

- **Online – UHCprovider.com/cardiology** > Sign In
- **Phone – 1-866-889-8054** Monday-Friday, 7 a.m. - 7 p.m. local time

Make sure the medical record is available.

For the most current list of CPT codes that require prior authorization, a prior authorization crosswalk and/or the evidence-based clinical guidelines, go to **UHCprovider.com/cardiology** > Sign In > Specific cardiology programs.

Dental services

Covered

A dental provider manual is available for detailed coverage information.

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services for adults ages 21 and older. If the member is older than 21, we do not provide coverage without the presence of trauma or cases where treatment is needed for serious medical conditions.

Facility services require a prior authorization.

The following services are for children ages 20 and under, pregnant members, the blind and nursing facility residents:

- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (limited)
- Restorative
- Oral and maxillofacial surgery
- Endodontics

Noncovered

UnitedHealthcare Community Plan does not cover routine dental services for anyone 21 years and older.

Refer to the Dental Provider Manual at **uhcdental.com** for applicable exclusions, limitations and covered services. Standard ADA coding guidelines apply to all claims.

To find a dental care provider, go to **UHCprovider.com** > Our Network > **Dental Providers by State > Network or Location Dental Directory.**

Durable medical equipment

Durable medical equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

See our Coverage Determination Guidelines at **UHCprovider.com/policies** > For Community Plans > **Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.**

Emergency/urgent care services

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate ER use. A PCP should treat nonemergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds and sore throats.

Covered services include:

- Hospital emergency department room and ancillary care provider service by in- and out-of-network care providers
- Medical exam
- Stabilization services
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services
- Emergency ground and air transportation
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage and cyst removal

We pay out-of-network care providers for emergency services at the current program rates at the time of service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed.

Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an ER are screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

After the member has received emergency care, the hospital must seek approval within 1 hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within 1 hour and/or they need to speak with a peer (medical director), call **1-800-955-7615.** The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. An MCO representative and the treating care provider reach an agreement about the member's care.
4. The member is released.

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. These are called post-stabilization services.

Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area.

Urgent care (nonemergent)

Urgent care services are covered. For a list of urgent care centers, contact **Provider Services** at **1-888-702-2202.**

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Nurses in the Health Services Department review emergency admissions within 1 business day of notification.

Deliver emergency care without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal at **UHCprovider.com/priorauth**, EDI 278N transaction at **UHCprovider.com/edi**, or call Provider Services.

UnitedHealthcare Community Plan makes utilization management (UM) determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize UM staff to support service underutilization. Care determination criteria is available upon request by contacting Provider Services (UM Department, etc.). The criteria are available writing upon request or by calling Provider Services.

For policies and protocols, go to **UHCprovider.com** > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans**.

If a member meets an acute inpatient level of stay, admission starts at the time you write the order.

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral.

They may also seek family planning services at the care provider of their choice. The following services are included:

- Annual gynecological exam
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services

Blood tests to determine paternity are covered only when the claim indicates tests were necessary for legal support in court.

Noncovered items include:

- Reversal of voluntary sterilization
- Hysterectomy for sterilization
- In vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy
  Note: Diagnosis of infertility is covered. Treatment is not.
  - Morning-after pill. Contact New Mexico to verify state coverage.

Parenting/child birth education programs

- Child birth education is covered
- Parenting education is not covered

Voluntary sterilization

In-network treatment with consent is covered. Before a member can get a tubal ligation or vasectomy, they first must give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent.

Out-of-network services require prior authorization.

View the New Mexico Health Care Authority (HCA) regulations for more information on sterilization.

Cancer Guidance Program

Cancer Guidance Program (CGP) is an evidence-based prior authorization/utilization management service that helps reduce medical expenses for high-cost, complex cancer treatments. UnitedHealthcare requires prior authorization for all cancer therapy with an administrative denial of any claim if an authorization is not on file.

- Injectable chemotherapy drugs (J9000–J9999)
- Leucovorin (J0640)
- Levoleucovorin (J0641)
- Levoleucovorin (J0642)
- Injectable chemotherapy drugs that have a Q code
- Colony-stimulating factors when requested for use to treat a cancer diagnosis
- Bone-modifying agent when requested for a cancer diagnosis
- Antiemetic drugs when requested for a cancer diagnosis
- Injectable chemotherapy drugs that have not yet received an assigned code and will be billed under a miscellaneous Healthcare Common Procedure Coding System (HCPCS) code will require prior authorization

Medical benefit drug policies provide the clinical criteria to determine the medical necessity of therapy.

Oncology medication clinical coverage

UnitedHealthcare recognizes indications and uses of injectable oncology medications, including therapeutic radiopharmaceuticals, listed in the NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus of 1, 2A, and 2B as proven and medically necessary, and Categories of Evidence and Consensus of 3 as unproven and not medically necessary.

- Preferred Products for bevacizumab, gemcitabine, leucovorin, trastuzumab, rituximab, Lupron
- White blood cell colony-stimulating factors
- Denosumab (Prolia® & Xgeva®)
- Antiemetics for oncology

Comprehensive prior authorization for radiation

Therapy services include the following:

- Intensity-modulated radiation therapy (IMRT)
- Proton beam therapy (PBT)
- Stereotactic body radiation therapy (SBRT), including stereotactic radiosurgery (SRS)
- Image-guided radiation therapy (IGRT)
- Special and associated services
- Fractionation using IMRT, PBT and standard 2D/3D radiation therapy for prostate, breast, lung and bone metastasis cancers
- Selective internal radiation therapy (SIRT), Yttrium-90 (Y90) and implantable beta-emitting microspheres for treatment of malignant tumors

For more information, visit **UHCprovider.com**.

Care coordination/health education

Our care coordination program is led by our qualified, full-time care coordinators. Please collaborate with us to help ensure members get care coordination services. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve members' quality of care, quality of life and health outcomes
- Help individuals understand and actively participate in the management of their condition and adhere to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with care providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision-making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based on evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in case management. The case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the care coordination program.

Programs are based on the findings from our Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs.

Facility admission notification requirements

Facilities are responsible for admission notification for the following inpatient admissions (even if an advanced notification was provided prior to the actual admission date):

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled nursing facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

Health Home program

Health Home provides community-based intensive care coordination and comprehensive care management to improve health outcomes and reduce service costs for some of the state's highest-need individuals. Health Home helps improve coordination of care and quality and increase individual participation in their own care.

The program reduces Medicaid inpatient hospital admissions avoidable ER visits, inpatient psychiatric admissions and the need for nursing home admissions. We work with area hospitals to provide transitional care services to members enrolled in Health Home. Hospitals and care providers may refer individuals to us for potential Health Home enrollment. New Mexico's state Medicaid agency determines Health Home eligibility. The program provides services beyond those typically offered by care providers, including:

- Comprehensive care management
- Care coordination and health promotion
- Individual and family support
- Referral to community services

For more information about Health Home, go to medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

Hearing services

1 pair of hearing aids per member every 4 years. This includes fitting, follow-up care, batteries and repair. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 20 years or younger.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization.

Home hospice

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is at home, under hospice and not receiving continuous home care. We cover hospice at the member's home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care.

Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver. Hospice inpatient respite care is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Inpatient hospice

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

Members receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. New Mexico Health Care Authority (HCA) covers residential inpatient hospice services. New Mexico Health Care Authority (HCA) will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory

The Preferred Lab Network webpage provides a full listing of eligible labs.

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by PCPs, other care providers or dentists in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

For more information on our in-network labs, go to **UHCprovider.com/findprovider** > **Preferred Lab Network**.

When submitting claims, have a Clinical Laboratory Improvement Amendment number (CLIA #). Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive. CLIA applies to all care providers rendering clinical laboratory and certain other diagnostic services.

See the **Billing and submission** chapter for more information.

Maternity/pregnancy/well-child care

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

Call Healthy First Steps at **1-800-599-5985.**

Healthy First Steps strives to:

- Identify expectant members early and enroll them in case management
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Provide multidisciplinary support for pregnant members to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed health care decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for nonemergent settings
- Encourage members to stop smoking with our Quit for Life tobacco cessation program
- Help identify and build the member's support system, including referrals to community resources and pregnancy support programs

Program staff act as a liaison between members, care providers and UnitedHealthcare for care coordination.

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the parent has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or had 7 or more prenatal visits.

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-888-702-2202** or go to **UHCprovider.com/priorauth**. For more information about prior authorization requirements, go to **UHCprovider.com/nmcommunityplan** > Prior Authorization and Notification.

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:

1. The member was in their second or third trimester of pregnancy when they became a UnitedHealthcare Community Plan member, and
2. They have an established relationship with a nonparticipating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care.

A UnitedHealthcare Community Plan member does not need a referral from their PCP for OB/GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for cesarean section require clinical information and medical necessity review.

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/priorauth**, or by calling **1-888-702-2202.**

Provide the following information within 1 business day of the admission:

- Date of admission
- Member's name and Medicaid ID number
- Obstetrician's name, phone number and provider ID
- Facility name (provider ID)
- Vaginal or cesarean delivery

If available at time of notification, provide the following birth data:

- Date of delivery
- Sex
- Birth weight
- Gestational age
- Baby name

Nonroutine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after the member's discharge require separate notification and will be subject to medical necessity review. The midwife must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives.

A Certified Nurse-Midwife (CNM) must identify a licensed care provider or group of care providers with whom they have arranged for referral and consultation if complications arise.

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through a nurse practitioner (N.P.), physician assistant (P.A.), or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

You do not have to be present when services are provided. However, you must assume professional responsibility for the medical services provided and help ensure approval of the care plan.

Post-maternity care

UnitedHealthcare Community Plan covers post-discharge care to the member and their newborn. Post-discharge care is based on accepted maternal and neonatal physical assessments and consists of a minimum of 2 visits. At least 1 visit is in the home. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is required for home health care visits for postpartum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

The hospital or care provider must notify the New Mexico Health Care Authority of delivery using either BabyBot or the Notification of Birth (MAD form 313) prior to discharge.

The hospital provides enrollment support by providing required birth data during admission.

Bright Futures assessment

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics. It is supported by the New Mexico Health Care Authority, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The Bright Futures Guidelines inform all preventive care screenings and well-child visits. You may incorporate Bright Futures into health programs such as home visits, child care and school-based health clinics. Materials developed for families are also available.

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

Settings for Bright Futures implementation include:

- Private practices
- Hospital-based or hospital-affiliated clinics
- Resident continuity clinics
- School-based health centers
- Public health clinics
- Community health centers
- Indian Health Service clinics
- Other primary care facilities

A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Home care and all prior authorization services

The discharge planner ordering home care should call Provider Services to arrange for home care.

Hysterectomies

A hysterectomy cannot be reimbursed if performed for sterilization. Members who get hysterectomies for medical reasons must be told, orally and in writing, they will no longer be able to have children.

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. The member should sign and date the form stating they were told before the surgery the procedure will result in permanent sterility.

Find the form on the New Mexico Health Care Authority (HCA) website.

See "Sterilization consent form" section below for more information.

Exception: New Mexico Health Care Authority (HCA) does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency in which prior acknowledgment was not possible. Include a description of the emergency.

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical assistance hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the member's ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. You cannot bill members if you do not submit consent forms.

Pregnancy termination services

Pregnancy termination services are not covered, except in cases to preserve the member's life. In this case, follow the New Mexico consent procedures for abortion.

Allowable pregnancy termination services do not require a referral from the member's PCP. Members must use the UnitedHealthcare Community Plan provider network.

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures are based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the State Medical Assistance Program must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

The member must not be mentally incompetent or live in a facility treating mental disorders. The member may agree to sterilization at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since signing the consent form. However, in the case of premature delivery, they must have signed the form at least 30 days before the expected delivery date. If the requirements are not met for both sterilization procedures and hysterectomies, UnitedHealthcare Community Plan cannot pay the care provider, anesthetist or hospital.

Sterilization informed consent

A member has only given informed consent if the Medical Assistance Consent Form for sterilization is properly filled out. Go to New Mexico Health Care Authority (HCA) and search for Medical Assistance Division to find the Medical Assistance Consent Form. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

- Complete all applicable sections of the consent form before submitting it with the billing form. The New Mexico Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Complete your statement section after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

You may also find the form on the New Mexico Health Care Authority (HCA) website.

Have 3 copies of the consent form:

1. For the member.
2. To submit with the Request for Payment form.
3. For your records.

Neonatal intensive care unit case management

The neonatal intensive care unit (NICU) management program manages inpatient and post-discharge NICU cases to improve outcomes and lower costs. Our dedicated team of NICU case managers, social workers and medical directors offer both clinical care and psychological services.

The NICU case management program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth. High-risk newborns placed in the NICU are eligible upon birth for NICU Case Management services.

The NICU Case Management team works closely with Neonatal Resource Services (NRS) team neonatologist and utilization management nurses, health plan registered nurses and social worker care managers to support and coordinate needed care for NICU infants and their families, as appropriate.

Inhaled nitric oxide

Use the guidelines for inhaled nitric oxide (iNO) therapy at **UHCprovider.com/policies** > For Community Plans > Medical and Drug Policies for Community Plan. Search for "Inhaled Nitric Oxide Therapy.

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to **UHCprovider.com/oncology** or call **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT.

Pharmacy

Pharmacy Preferred Drug List/Prescription Drug List

The New Mexico UnitedHealthcare Community Plan **Preferred Drug List/Prescription Drug List (PDL)** helps you select medically appropriate, high-quality and cost-effective drugs for members. This list applies to all UnitedHealthcare Community Plan of New Mexico members. Specialty drugs on the PDL are identified by a "SP" in the "Requirements and Limits" section of each page.

You must prescribe Medicaid members drugs listed on the PDL. We may not cover brand-name drugs not on the PDL if an equally effective generic drug is available and is less costly unless prior authorization is followed.

If a member requires a nonpreferred medication, call Pharmacy Prior Authorization at **1-800-310-6826** or use the online Prior Authorization and Notification tool on the **UnitedHealthcare Provider Portal.**

We provide you PDL updates before the changes go into effect. Change summaries are posted on **UHCprovider.com**. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

Pharmacy prior authorization

Medications can be dispensed as an emergency 72-hour supply when drug therapy must start before prior authorization is secured, and the prescriber cannot be reached. The rules apply to nonpreferred PDL drugs and to those affected by a clinical prior authorization edit.

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-310-6826.** We provide notification for prior authorization requests within 24 hours of request receipt.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has 1 or more of the following characteristics:

- Used by a small number of people
- Treats rare, chronic and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable or inhaled

Specialty pharmacy medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to **UHCprovider.com/priorauth**.

Radiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain prior authorization for the following advanced imaging procedures if you provide them in an office or outpatient setting:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)
- Nuclear cardiology

Advanced imaging procedures do not require prior authorization if performed in the following places of service:

- Emergency rooms
- Hospital observation units
- Urgent care centers
- Inpatient settings

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone at:

- **Online** – **UHCprovider.com/radiology** > Sign In
- **Phone** – **1-866-889-8054** Monday-Friday, 7 a.m.– 7 p.m. local time. Make sure the medical record is available

For a current list of CPT codes that require prior authorization, a prior authorization crosswalk table and/or the evidence-based clinical guidelines, go to **UHCprovider.com/radiology** > Sign In > Specific Radiology Programs.

Screening, brief interventions and referral to treatment services

Screening, brief interventions and referral to treatment (SBIRT) services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed care provider within the scope of their practice

- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change and making appropriate referrals as needed
- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per care provider per calendar year.

What is included in screening, brief interventions and referral to treatment services?

Screening

With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug/substance use problems and determine how severe those problems already are. Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention

If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

Referral to treatment

Refer members whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the alcohol and drug program in the county where the member resides for treatment.**

SBIRT services will be covered when all are met:

- The billing care provider and servicing care provider are SBIRT-certified
- The billing care provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is Z71.41
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per care provider, per year
- The SBIRT assessment, intervention or treatment takes places in one of the following places of service:
- Office
- Urgent care facility
- Outpatient hospital
- ER – hospital
- FQHC
- Community behavioral health center
- Indian Health Service
- Tribal health care providers 638 freestanding facility
- Homeless shelter
- Urban Indian care providers

For more information about E/M services and outreach, see online guide.

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The FDA-approved medications for OUD include buprenorphine, methadone and naltrexone.

To prescribe buprenorphine, you must have a current registration with the United States Drug Enforcement Agency (DEA) and be authorized to prescribe buprenorphine in the state.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health care provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MAT care provider in New Mexico:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Medical Care Directory."
3. Click on "Medicaid Plans."
4. Select "(state)."
5. Click on the applicable plan name.
6. In the search field, type "Medication Assisted Treatment" and click "Search."

If you have questions about MAT, please call **Provider Services** at **1-888-702-2202** and enter your TIN. Say "Representative," and "Representative" a second time. Then say "Something Else" to speak to a representative.

Tuberculosis screening and treatment

Guidelines for tuberculosis (TB) screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Vision

Vision services are covered by March Vision Care. Please see the March Vision Care reference guide for information such as compliance, electronic payment information, safety resources and training. You can also call 1-844-706-2724.

Waiver programs

Human immunodeficiency virus/acquired immune deficiency syndrome waiver program

The Human immunodeficiency virus/acquired immune deficiency syndrome waiver program (HIV/AIDS) program is available to members who would otherwise require long-term institutional services.

Identification

Members with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The care coordinator or the PCP may identify members potentially eligible for the waiver program. They may also inform the member of the waiver program services.

Referral

If the member agrees to participation, provide the waiver agency with supportive documentation, including history and physical, any relevant labs or other diagnostic study results and current treatment plan.

Continuity of care

The HIV/AIDS waiver program will coordinate in-home, home- and community-based services (HCBS) in collaboration with the PCP and care coordinator. If the member does not meet criteria for the waiver program, or declines participation, the health plan will continue care coordination as needed to support the member.

Other federal waiver programs

Other waiver services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for members who may benefit from HCBS. These members are referred to the Long-Term Care Division/HCBS branch to determine eligibility and availability. If deemed eligible, the health plan will continue to cover all medically necessary covered services for the member unless/until member is disenrolled from the Medicaid program.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering care provider name and TIN/NPI number
- Rendering care provider and TIN/NPI number
- ICD clinical modification (CM)
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI number, when applicable

For behavioral health and substance use disorder authorizations, please contact Optum Behavioral Health at **1-877-614-0484.**

If you have questions, go to New Mexico's prior authorization page at **UHCprovider.com/nmcommunityplan** > Medicaid > Prior Authorization and Notification Resources.

The following table lists medical management notification requests and the amount of time required for a decision, approval or denial.

Type of request	Decision turnaround time	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent pre-service.	Within 7 business days after receipt of all necessary and relevant documentation.		
Urgent/expedited pre-service.	24 hours after the receipt of all necessary and relevant documentation supporting the prior authorization request.		
Concurrent review.	Within 72 hours.	Notified within 72 hours of determination.	Notified within 72 hours of determination and member notification within 3 business days.
Retrospective review.	Within 30 calendar days of receiving all pertinent clinical information.	Within 24 hours of determination.	Within 24 hours of determination and member notification within 2 business days.

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities. We perform a record or phone review for each day's stay using InterQual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

Concurrent review details

Concurrent review is notification within 72 hours or 3 business days of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning. This includes:

- Primary and secondary diagnosis
- Clinical information
- Care plan
- Admission order
- Member status
- Discharge planning needs
- Barriers to discharge
- Discharge date

When available, provide clinical information by access to electronic medical records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director.

UnitedHealthcare Community Plan uses InterQual, CMS guidelines or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings.

This includes:

- Acute and sub-acute medical
- Long-term acute care
- Acute rehabilitation
- SNFs
- Home health care
- Ambulatory facilities

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition or disability
- Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote daily activities; remember the member's functional capacity and capabilities appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member

We don't consider experimental treatments medically necessary.

Determination process

Benefit coverage for health services is determined by the member's specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, Summary Plan Description and applicable laws. You may freely communicate with members about their treatment, regardless of benefit coverage limitations.

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to **UHCprovider.com**.

Medical and drug policies and coverage determination guidelines

Find medical and drug policies and guidelines at **UHCprovider.com/policies** > **For Community Plans**.

Referral guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization of all out of-network referrals. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are approved for, but not limited to, the following:

- Continuity of care issues
- Necessary services are not available within network

UnitedHealthcare Community Plan monitors out-of-network referrals on an individual basis. Care provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Reimbursement

UnitedHealthcare Community Plan of New Mexico authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by using the **UnitedHealthcare Provider Portal**, contacting UnitedHealthcare Community Plan's Provider Services department, or the New Mexico Medicaid Eligibility System
- Submit documentation needed to support the medical necessity of the requested procedure
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized
- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Noncovered services
- Services provided to members not enrolled on the date(s) of service

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the New Mexico Health Care Authority (HCA) . These access standards are defined in **Chapter 2**. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a nonparticipating care provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-888-702-2202.**
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services requiring prior authorization

Direct access services – Native Americans

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization.

Seek prior authorization within the following time frames

- **Emergency or urgent facility admission** – 1 business day
- **Inpatient admissions; after ambulatory surgery** – 1 business day
- **Nonemergency admissions and/or outpatient services (except maternity)** – at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Utilization management guidelines

Utilization management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a FFS basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a FFS basis. The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions. Call **1-888-702-2202** to discuss the guidelines and utilization management.

Utilization management appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care or other health care services determination. They do not include benefit appeals, which are appeals for noncovered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal.

Chapter 5: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/prevention

Key contacts

Topic	Links	Phone number
Vaccines for Children	nmhealth.org/about/phd/idb/imp/vfc/	1-833-882-6454

The **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid.

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members up to age 21, including pregnant members. EPSDT screening includes the following:

- Immunizations
- Hearing
- Vision
- Speech screening and nutritional assessments
- Dental screening
- Growth and development tracking

For complete details about diagnoses codes as well as full and partial screening, examination and immunization requirements, go to the EPSDT schedule at **UHCprovider.com/nmcommunityplan**.

Abuse examinations

Medicaid covers sexual assault findings examination (SAFE) and child abuse resource education (CARE) exams. It also covers related laboratory studies that determine sexual or physical abuse. The exam is performed by SAFE-trained care providers certified by the Department of Health and Senior Services. Children enrolled in a managed health care plan receive SAFE-CARE services through New Mexico Medicaid on a FFS basis. Call New Mexico Medicaid for more information.

Developmental disability services and coordination with regional centers

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood.

These disabilities include intellectual disability, cerebral palsy, epilepsy, autism and disabling conditions related to intellectual disability or requiring similar treatment. The Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management and community support of persons with intellectual disability, cerebral palsy, epilepsy and autism for children older than 36 months to adulthood.

Referral

If you determine that supportive services would benefit the member, refer the member to DDS for approval and assignment of a regional center case manager who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the regional center interdisciplinary team. While the regional center does not provide overall case management for their clients, they must assure access to health, developmental, social and educational services from birth throughout the lifespan of individual who has a developmental disability.

Continuity of care

The regional center will determine the most appropriate setting for eligible HCBS and will coordinate these services for the member in collaboration with the PCP and health plan coordinator. The care coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary and therapeutic covered services

First Steps program

The First Steps program provides early intervention services to infants and toddlers with disabilities or developmental delays from birth to age 3 and their families. The state of New Mexico handles this program.

Referring a child

Refer a child to First Steps services if the child has a visual, hearing or severe orthopedic impairment, or any combination of these impairments, or if the child potentially requires other developmental intervention services.

How to refer

Website: sharenm.org/first-steps-program/first-steps-program

Phone: 1-575-751-5764

Provide information requested to complete the program.

Next steps

The First Steps team will evaluate your request to determine eligibility. Then a First Steps service coordinator will be assigned to help the child's parents through the process. The assigned coordinator from First Steps will contact you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the individualized family service plan (IFSP). UnitedHealthcare Community Plan provides member case management and care coordination for the IFSP. If the child has complex needs, a UnitedHealthcare Community Plan care manager will be assigned as well if we are aware of the situation.

Full screening

Perform a full screen. Include:

- Interval history
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately)
- Lead assessment
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental

Without all these components, you cannot bill for a full screen. You may only bill for a partial screen.

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. Office visits and full or partial screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

Interperiodic screens are often used for school and athletic physicals. A physical exam may be needed for a certificate stating a child is physically able to take part in school athletics. This also applies for other school physicals when required as conditions for educational purposes.

Lead screening/treatment

Call Provider Services if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

Targeted case management

Targeted case management (TCM) consists of case management services for specified targeted groups to access medical, social, educational and other services provided by a regional center or local governmental health program as appropriate.

Identification

The 5 target populations include:

- Children younger than 21 at risk for medical compromise
- Medically fragile individuals
- Individuals in frail health, older than 18 and at risk of institutionalization
- Members in jeopardy of negative health or psychosocial outcomes
- Members infected with a communicable disease, including TB, HIV/AIDS, etc., or who have been exposed to communicable diseases, until the risk of exposure has passed

Referral

Refer eligible members to a regional center or local governmental health program, as appropriate, for TCM services. To refer, contact your local community mental health center (CMHC). If you're not sure who your local CMHC is, call Behavioral Health (BH) Member Services at **1-877-236-0826.**

Continuity of care

UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM care provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM care provider that are covered services under the contract.

Vaccines for Children

The Vaccines for Children (VFC) program provides immunizations. Immunizations offered in the state VFC program must be ordered by your office. We do not reimburse for the vaccine ordered by the VFC program, but we reimburse for administering the vaccine.

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code. We cannot reimburse for private stock vaccines when they are available through VFC.

Contact New Mexico VFC if you have questions at 1-833-882-6454.

Any child through 18 years of age who meets at least one of the following criteria is eligible for the VFC program:

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured (These children have health insurance, but the benefit plan does not cover immunizations. Children in this category may not only receive vaccinations from a FQHC or RHC. (They cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine.)

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-888-702-2202**
Value-added services	**UHCCommunityPlan.com/nm** > View plan details	**1-877-236-0826**

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call UnitedHealthcare **Provider Services** at **1-888-702-2202** unless otherwise noted.

AbleTo (self care)

An on-demand digital program rooted in cognitive behavioral therapy (CBT) methods. The program offers tools and content to help build mental wellness

Acupuncture services

Up to 5 visits per year are covered.

Assurance

In partnership with Assurance Wireless, UnitedHealthcare works with the member to promote the federal Lifeline program which enables members with varying offers of data, talk and text.

Car seats

Pregnant members can get a car seat for safe infant travel. Limited to 1 car seat (up to $150) per infant delivery.

Electroconvulsive therapy

Medical treatment for severe mental illness in which a small, carefully controlled amount of electricity is introduced into the brain and is used to treat a variety of psychiatric disorders, including severe depression.

Emergency clothing fund for children

Provides up to $100 per child per year to help parents/guardians buy clothing and/or shoes for school-aged children.

Home-delivered meals

Home-delivered, medically tailored, culturally appropriate meals to promote better health and support health care for persons in transition.

Hypoallergenic pillowcases and mattress cover

1 mattress and 2 pillow cases per year. Allowed for members aged 3-21 with a diagnosis of asthma and/or allergies.

One Pass fitness program

Members 18 and older can get unlimited access to many local gyms, including the YMCA. Explore online workouts and join live classes virtually, from the comfort of home.

Platinum diet and nutritional counseling

Dietary counseling for any UnitedHealthcare member with any network care provider.

Social drivers of health employment and education

Up to $300 to help with education and employment such as school supplies, GED fees, back to school haircuts, registration fees for after school activities and summer programs, drop-in daycare cost for job interviews, work force development and/or qualifying phone ($20) for Assurance wireless program.

Social drivers of health helping out mom and baby

A Pack n Go Play Pen or Stroller and/or diapers up to $175 per member.

Social drivers of health home modifications for a healthier environment

Up to $300 per member to help with the cost of nonstructural home modifications for a healthier environment such as improving air quality with air purifiers, portable air conditioning, addressing non-slip mats and grab bars to prevent falls, and wheelchair ramps when possible.

Social drivers of health keeping healthy while waiting for assistance

Up to $500 per member: healthy food boxes or infant formula while waiting on benefits approval or on community-based wait lists for resources.

Social drivers of health move-in assistance

Up to $300 per member to assist with the fees associated with moving into a new home such as becoming ID ready, applying for housing, and deposits.

Substance use disorder helpline

An anonymous helpline to talk about issues with substance use. Connects members, family and friends with a behavioral health expert.

Traditional and cultural services support

Members have access to healing, wellness, and cultural services and support at participating care providers.

UnitedHealthcare gold card transportation

Members have access to rides for non-medical services such as Women, Infants and Children (WIC) appointments, birthing classes, places of worship, job related activities, a laundromat, a food pantry or grocery store. Family members or caregivers may also ride with members

UnitedHealthcare Platinum dental

Members 21+ can get 1 fluoride treatment every 6 months and up to 4 teeth cleaning per year. They can also choose to get 1 lifetime fluoride varnishing treatment.

UnitedHealthcare Platinum hearing

Hearing aids, hearing aid batteries, insurance and ear molds are covered.

UnitedHealthcare Platinum vision

Two frames and lenses for Turquoise Care age 20 and under every 12 months & 1 routine exam and frame and lenses for Turquoise Care 21+ every 12 months.

UnitedHealthcare VIP member solutions

One on one manager support for complex member needs.

Chapter 7: Behavioral health and substance use

Key contacts

Topic	Link	Phone number
Provider Services	For chat options and contact information, visit **UHCprovider.com/contactus**.	**1-888-702-2202**
Behavioral health authorizations/ Provider Express	**providerexpress.com**	**1-877-614-0484**

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members with mental health and substance use disorder (SUD) benefits. The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law.

The Optum Behavioral Health National Network Manual is located on **providerexpress.com**.

This chapter does not replace the national Optum network manual. Rather, it supplements the national manual by focusing on Medicaid's specific services and procedures.

You must have an NPI number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to the Healthy Care Authority (HCA) search for "Apply to be a Medicaid Provider."

How to join our network: Credentialing information is available at **providerexpress.com** > **Our Network**.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders. We offer care management to help members, clinicians and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in 1 place. **liveandworkwell.com**, accessed through a link on **myuhc.com**, includes mental health and well-being information, plus articles on health conditions, addictions and coping. It also provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

For member resources, go to **providerexpress.com** click on the Live and Work Well (LAWW) link at the bottom of the page. LAWW includes tools to help members address mental health and substance use issues. Access the site using the guest access code "Clinician."

Benefits include but are not limited to:

- Crisis stabilization services (includes treatment crisis intervention and Mobile Crisis)
- Inpatient psychiatric hospital (acute and sub-acute)
- Residential treatment
- Outpatient assessment and treatment:
  - Applied Behavior Analysis (ABA)
  - Partial hospitalization
  - Detoxification
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services

- Evidence-based practices:
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telehealth
- Case management
- Rehabilitation services

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online using the Eligibility and Benefits tool on the **UnitedHealthcare Provider Portal** > Sign In.

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering nonemergent services. Request prior authorization using the Prior Authorization and Notification tool on the portal or by calling **1-888-702-2202**.

Collaboration with other care providers

Coordination of care

When a member is receiving services from more than 1 professional, you must coordinate to deliver comprehensive, safe and effective care. This is especially true when the member:

- Is prescribed medication
- Has coexisting medical/psychiatric symptoms
- Has been hospitalized for a medical or psychiatric condition and needs a day 7 follow-up appointment

Please talk to your patients about the benefits of sharing essential clinical information.

UnitedHealthcare Provider Portal access

You can use the **UnitedHealthcare Provider Portal** for all of your online services, including claims, eligibility, prior authorization, referrals and much more. The portal allows you to take action and quickly access claims-related information using our digital features and tools. It's a one-stop shop for working with us more efficiently.

Claims

Submit claims using the claim form CMS 1500 (v 02/12) or UB-04 form and review for version listed, whichever is appropriate.

Use applicable coding, including ICD diagnosis code(s), CPT, revenue and HCPCS modifier coding. Include all necessary data to process a complete claim. Find out more about filing claims in **Chapter 11.**

Monitoring audits

We conduct routine care provider on-site audits. These audits focus on the physical environment, policies and procedures, and quality record documentation.

Training resources and materials

We provide the following resources to assist you in your practice and to help your patients.

- **Behavioral health toolkits**
- **Provider training materials**
- **Network provider manuals**

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction.

Brief summary of framework

- **Prevention**
  - Prevent OUDs before they occur through pharmacy management, care provider practices and education

- **Treatment**
  - Access and reduce barriers to evidence-based and integrated treatment
- **Recovery**
  - Support case management and referral to person-centered recovery resources
- **Harm reduction**
  - Access to naloxone and facilitating safe use, storage and disposal of opioids
- **Strategic community relationships and approaches**
  - Tailor solutions to local needs
- **Enhanced solutions for pregnant members and their children**
  - Prevent neonatal abstinence syndrome and supporting birth parents in recovery
- **Enhanced data infrastructure and analytics**
  - Identify needs early and measure progress

Increasing education and awareness of opioids

You must be up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on the portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resource.

Access these resources at **UHCprovider.com/pharmacy.** Click “Opioid Programs and Resources-Community Plan” to find a list of tools and education.

Prescribing opioids

Go to our **Drug Lists and Pharmacy** page to learn more about which opioids require prior authorization and if they have prescription limits.

Pharmacy lock-in

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse (e.g., narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy.

Expanding medication assisted treatment access and capacity

Evidence-based medication assisted treatment (MAT) treatment is central to opioid use disorder (OUD) treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other comprehensive services, such as counseling, cognitive behavioral therapies and recovery support. We expand MAT access and help ensure we have an adequate member MAT network.

To find a behavioral health MAT care provider in New Mexico:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Behavioral Health Directory."
3. Click on "Medicaid plans."
4. Select "(state)."
5. Click on the applicable plan name.
6. In the search field, type "Medication Assisted Treatment" and click "Search."

We contract with OUD Centers of Excellence (where available), which are designated as premier facilities to help ensure people with OUD stay in treatment and receive appropriate follow-up care and supports within their communities.

To find medical MAT care providers, see the MAT section in **Chapter 4.**

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/nm**	**1-877-236-0826**
Member handbook	**UHCCommunityPlan.com/nm** > Community Plan > Member benefits	

Our member handbook **UHCCommunityPlan.com/nm** has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy.

Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to Protected Health Information

Members may access their medical records or billing information either through you or us. If their information is electronic, they may ask that you or we send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of Protected Health Information

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request. This accounting must include disclosures by business associates.

It will not include disclosures made:

- For treatment, payment and health care operations purposes
- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not require us to give an accounting

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member right and responsibilities

The following information is in the member handbook at the following link under the Member Information tab: **UHCprovider.com/nmcommunityplan**.

Native American access to care

Native American members can access care at Tribal Clinics and Indian Health Service Facilities without approval.

Additionally, Native American members are not subject to the UnitedHealthcare Turquoise Care Formulary if they use their pharmacy benefit at an Indian Health Service, Tribal Health Care Provider, or Urban Indian Facility.

Members rights

Members have the right to:

- Request information on advance directives
- Be treated with respect, dignity and privacy
- Receive cultural assistance, including having an interpreter during appointments and procedures
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, or coercion to force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Does not apply to those in a lock-in
- Tell us their opinions and concerns about services and care received
- Register grievances concerning the health plan or the care provided
- Appeal any payment or benefit decision we make
- Review the medical records you keep and request changes and/or additions to any area they feel is needed
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit covered
- Make suggestions about our member rights and responsibilities policies
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member ID card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the ER only during a serious threat to life or health
- Notify us of any change in address or family status
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it

- Give you and us information that could help improve their health
- Notify us of any change in eligibility status

Additionally, Native American members are not subject to the UnitedHealthcare Turquoise Care Formulary if they use their pharmacy benefit at an Indian Health Service, Tribal Health Provider, or Urban Indian Facility. Our member rights and responsibilities help uphold the quality of care and services they receive from you.

The 3 primary member responsibilities as required by the National Committee for Quality Assurance (NCQA) are to:

1. Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care.
2. Follow care to which they have agreed.
3. Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible.

Chapter 9: Medical records

Medical record charting standards

You are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying UnitedHealthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral health care providers
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 24 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing medical records. • Release only to entities as designated consistent with federal requirements • Keep in a secure area accessible only to authorized personnel
Procedural elements	**Medical records are readable*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*

***Critical element**

Topic	Contact
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: – Recommended preventive health screenings/tests – Depression – High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit – Medicare members for functional status assessment and pain – Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise, nutrition and counseling, as appropriate
Problem evaluation and management	Documentation for each visit includes: • Appropriate vital signs (measurement of height, weight and BMI annually): – Chief complaint* – Physical assessment* – Diagnosis* – Treatment plan* • Tracking and referral of age and gender-appropriate preventive health services consistent with preventive health guidelines • Documentation of all elements of age-appropriate federal Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets • Treatment plans are consistent with evidence-based care and with findings/diagnosis: – Time frame for follow-up visit as appropriate – Appropriate use of referrals/consults, studies and tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review • There is evidence of care provider follow-up of abnormal results • Unresolved issues from a previous visit are followed up on the subsequent visit • There is evidence of coordination with behavioral health care provider • Education, including lifestyle counseling, is documented • Member input and/or understanding of treatment plan and options is documented • Copies of hospital discharge summaries, home health care reports, emergency room care and practitioner are documented

***Critical element**

Member copies

A member or their representative is entitled to 1 free copy of their medical record. Additional copies may be available at the member's cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame (e.g., immunization and TB records required for lifetime).

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 2 visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of advance directive, or other document as allowed by state law, or note the member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies including follow-up plans

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone number
Credentialing	Medical: Network management support team Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. Chiropractic: **myoptumhealthphysicalhealth.com**	**1-877-614-0484**
Fraud, waste, and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the Quality Improvement program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement (QI) program falls under the leadership of the CEO and the chief medical officer. A copy of our QI program is available upon request.

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of care providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhancing patient safety
- Tracking member and care provider satisfaction and taking actions as appropriate

As a participating care provider, you may offer input through representation on our QI committee and your Provider Services representative/provider advocate.

Cooperation with quality-improvement activities

You must comply with all QI activities. These include:

- Providing requested timely medical records
- Cooperating with quality-of-care investigations — for example, responding to questions and/or completing quality-improvement action plans
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual HEDIS record review
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits, email or secure email.
- Completing practitioner appointment access and availability surveys

We require your cooperation and compliance to:

- Allow the plan to use your performance data
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

Care provider satisfaction

Every year, we conduct care provider satisfaction assessments as part of our QI efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys
- Regular visits
- Town hall meetings

Our main concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our QI committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit **UHCprovider.com/cpg** to view the guidelines, as they are an important resource to guide clinical decision-making.

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable New Mexico statutes and the National Committee for Quality Assurance (NCQA) The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current DEA certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan provider network. You must go through the credentialing and recredentialing process before you may treat our members. Meet the credentialing and recredentialing standards and be eligible to enroll with Health Care Authority (HCA) as Medicaid Provider.

We credential physicians, health care providers and facilities who want to join our network and be listed in our Provider Directory. Our credentialing program helps us maintain and improve the quality of care and services delivered to our members. Our credentialing standards are fully compliant with the NCQA, CMS and New Mexico state requirements. We have a thorough, written credentialing program outlined in our Credentialing Plan on **UHCprovider.com/join.**

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- M.D.s (Doctors of Medicine)
- D.O.s (Doctors of Osteopathy)
- D.D.S.s (Doctors of Dental Surgery)
- D.M.D.s (Doctors of Dental Medicine)
- D.P.M.s (Doctors of Podiatric Surgery)
- D.C.s (Doctors of Chiropractic)
- C.N.M.s (Certified Nurse-Midwives)
- C.R.N.P.s (Certified Nurse Practitioners)
- P.A.Cs (Physicians Assistants)
- Behavioral health clinicians (psychologists, clinical social workers, masters prepared therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility

Health facilities

Facility care providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements. Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and an NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or another recognized accrediting agency

- Have no Medicare/Medicaid sanctions

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website at caqh.org.

Go to **UHCprovider.com/join** to submit a participation request.

For chiropractic credentialing, call **1-800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 form

Peer review

Credentialing process

4.8.16.7.10 Notify care providers of credentialing decisions (approved or denied) within 10 calendar days of the credentialing committee or peer review body.

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. Credentialing applications will be completely processed within 30 calendar days from receipt of a complete application with all required primary source documentation. We will notify you of the decision in writing within 10 calendar days of the review.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website at caqh.org. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its QI database for information about your performance. This includes member grievances and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections of notification by phone, or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing application; please connect with a live advocate via chat. It is available 7 a.m.- 7 p.m. CT at **UHCprovider.com/chat**.

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

Failure to meet recredentialing requirements

If you don't meet our recredentialing requirements, we will end your participation with our network. We will send you a written termination notice in compliance with applicable laws, regulations and other requirements.

Resolving disputes

Contract concerns

If you have a concern about your Agreement with us, send a letter to:

UnitedHealthcare Community Plan
Central Escalation Unit
P.O. Box 5032
Kingston, NY, 12402-5032

A representative will work to resolve the issue with you. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your Provider Agreement.

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or care coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, please follow the dispute resolution provisions in your Provider Agreement.

If we have a concern about our Agreement with you, we will send you a letter. If the issue can't be resolved this way, please follow the dispute resolution provisions in your Provider Agreement.

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the member handbook on **UHCprovider.com/nmcommunityplan/member handbook** and **Chapter 12** of this manual.

Health Insurance Portability and Accountability Act compliance – your responsibilities

Health Insurance Portability and Accountability Act (HIPAA) aims to improve the efficiency and effectiveness of the United States health care system. While the act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations — as are all care providers who conduct business electronically.

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA. Otherwise, submit claims using a clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, care providers, health plans and individuals for use in standard transactions.

National Provider Identifier

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on FFS claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance consumers' rights by giving them access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations
- Help ensure compliance with the security regulations by the covered entity's staff

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at cms.hhs.gov.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

1. Oversight of the Ethics and Integrity program.
2. Development and implementation of ethical standards and business conduct policies.
3. Creating awareness of the standards and policies by educating employees.
4. Assessing compliance by monitoring and auditing.
5. Responding to allegations of violations.
6. Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
7. Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Critical incident

Critical Incident (CI) is defined as an occurrence, that involves a recipient and requires the program to respond in a manner that is not a part of the program's ordinary daily routine including but not limited to:

- Abuse
- Neglect
- Exploitation
- Death
- Environmental hazard
- Law enforcement intervention
- Emergency services
- Member hospitalization
- Severe harm
- Abduction
- Elopement
- Sexual abuse or assault
- Flame or unanticipated smoke, heat, or flashes occurring during an episode of member care

Critical Incident reporting requirements

The Human Services Dept/Medical Assistance Division/ Quality Bureau (HSD/MAD/QB) incident management system describes the statewide reporting requirements for all incidents involving recipients served under Turquoise Care funded Home and Community-Based Service programs. Community agencies providing Home and Community-Based Services are required to report Critical Incidents to the State.

Home & Community Based-Services include personal care services (PCO) and self-directed benefit services in addition to other services. All allegations of abuse, neglect, and exploitation of a recipient must be reported, as well as any incidents involving emergency services, hospitalization, the death of a recipient, the involvement of law enforcement, any environmental hazards that compromise the health and safety of a recipient, and any elopement or missing recipient.

Incident Management Principles

- All adults and children receiving Turquoise Care Home and Community-Based Services should be able to enjoy a quality of life that is free of abuse, neglect, and exploitation
- Direct staff providing services and the agencies that employee then must receive training to be competent to respond to, document incidents, in a timely and accurate manner
- Recipients, legal representatives, and guardians must be made aware of and have available incident reporting processes
- Any individual who, in good faith, reports an incident or makes an allegation of abuse, neglect, or exploitation will be free from any form of retaliation
- Quality starts with those who work most closely with persons receiving services

Critical Incident reporting - specific to emergencies, abuse or neglect

- If the Critical Incident has 911 needs. UnitedHealthcare employees will follow the UnitedHealthcare Consumer Safety policy for emergency calls received and follow up with documentation on the Critical Incident form
- If the Critical Incident involves, abuse, neglect or exploitation and there is no indication that the referral source has already been reported, the QIS Critical Incident clinician will report it immediately to the county Department of Social Services in which the suspected activity occurred. If the activity involves a parent, guardian or caretaker report using the telephone number below:
  - Children Abuse or Neglect: 1-855-333-7233
  - Adult Protective Services: 1-866-654-3219
  - All incidents must be reported immediately through the 24/7 toll free Abuse, Neglect and Exploitation Reporting Hotline at 1-800-445-6242

Physical health and behavioral health care provider training

Care providers are required to complete training on Critical Incidents at least annually. UnitedHealthcare Community Plan provides ongoing training covering UnitedHealthcare Community Plan procedures and expectations for CI reporting and management to all subcontracted individual care providers, care provider agencies and its members who are receiving self-directed services, to include his or her employees.

- Training provided includes a component on Protected Health Information Security and HIPAA
- UnitedHealthcare Community Plan will instruct physical health and behavioral health care providers initially, and then annually thereafter, on the required processes for reporting CIs and sentinel events as required by the agency or department that has oversight of the report, including but not limited to: New Mexico Health Care Authority (HCA), Department of Health (DOH), Children Youth and Families Department (CYFD) and Aging & Long-Term Services Department

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

UnitedHealthcare Community Plan's special investigations unit (SIU) is an important part of the compliance program.

The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities. To report questionable incidents involving members or care providers, call our Fraud, waste and abuse line, go to **uhc.com/fraud,** or refer to the **Fraud, waste, and abuse** section of this care provider manual for additional details.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of New Mexico to perform individual and corporate extrapolation audits. This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the New Mexico Health Care Authority (HCA).

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the New Mexico program agreement between the state and UnitedHealthcare Community Plan or another period as required by law.

If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth®) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet New Mexico program standards.

You must cooperate with the state or any of its authorized representatives, the New Mexico Health Care Authority, Centers for Medicare and Medicaid, the Office of Inspector General (OIG), or any other agency prior-approved by the state, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Provider Agreement.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this care provider manual.

Site visits

UnitedHealthcare Community Plan and affiliates complete site visits. A site visit is an opportunity to meet face-to-face and share information. Site visits are also conducted to monitor grievances for quality of care (QOC) and service concerning participating care providers and facilities. Grievances about you or your site are recorded and investigated.

We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment.

For this reason, UnitedHealthcare Community Plan has set clinical site standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance
- Available handicapped parking
- Handicapped accessible facility
- Available adequate waiting room space
- Adequate exam room(s) for providing member care
- Privacy in exam room(s)
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

QOC issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety.	Access to facility in poor repair to pose a potential risk to patients. Needles and other sharps exposed and accessible to patients. Drug stocks accessible to patients. Other issues determined to pose a risk to patient safety.	1 grievance.
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space.	Office facilities are dirty; smelly or otherwise in need of cleaning. Office exams rooms do not provide adequate privacy.	2 grievances in 6 months.
Other.	All other grievances concerning the office facilities.	3 grievances in 6 months.

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	**UHCprovider.com/claims**	**1-866-633-4449**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-800-210-8315**

Our claims process

For claims, billing and payment questions, go to **UHCprovider.com/claims**.

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) on **UHCprovider.com/guides**.

Claims process from submission to payment

1. You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.
2. All claims are checked for compliance and validated.
3. Claims are routed to the correct claims system and loaded.
4. Claims with errors are manually reviewed.
5. Claims are processed based on edits, pricing and member benefits.
6. Claims are checked, finalized and validated before sending to the state.
7. Adjustments are grouped and processed.
8. Claims information is copied into data warehouse for analytics and reporting.
9. We make payments as appropriate.

If you think we processed your claim incorrectly, please see the **Claims reconsiderations, appeals and grievances** chapter in this care provider manual for next steps.

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.

If you have not applied for an NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan, call Provider Services. Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or noncovered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

Reimbursements also depend on the fee schedule and the procedure performed. Refer to your bulletins for correct coding.

Modifier codes

Use the appropriate modifier codes on your claim form. Find our modifier reference policies in our **Community Plan Reimbursement Policies** by searching for "modifier." The modifier must be used based on the date of service.

Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill with the member ID.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on CMS 1500 and UB-04 claim forms.

- Use the CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services
- Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers

Clean claims and submission requirements

Complete a CMS 1500 or UB-04 form whether you submit an electronic or a paper claim. Clean claims have:

- A health service provided by an eligible care provider to a covered UnitedHealthcare Community Plan member
- All the required documentation, including correct diagnosis and procedure codes
- The correct amount claimed

We may require additional information for some services, situations or state requirements.

Submit any services completed by N.P.s or P.A.s who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims according to their agreement.

Care provider coding

UnitedHealthcare Community Plan complies with EPSDT state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies.** Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

Electronic claims submission and billing

You may submit claims by electronic data interchange (EDI). EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- All claims are set up as “commercial” through the clearinghouse
- Our payer ID is 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don’t successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for CMS 1500 and UB-04 forms

For more information, see electronic data interchange Claims section.

Electronic data interchange companion documents

The UnitedHealthcare Community Plan electronic data interchange (EDI) companion documents are intended to share information within implementation guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan’s business purposes when the IG allows multiple choices

- Provide values the health plan will return in outbound transactions
- Outline which situational elements the health plan requires

The companion document provides general information and specific details pertinent to each transaction. Share these documents with your software vendor for any programming and field requirements. The companion documents are located on **UHCprovider.com/edi** > **EDI Companion Guides**.

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, go to **UHCprovider.com/edi** > **EDI Clearinghouse Options**

e-Business support

Call Provider Services for help with online billing, claims, electronic remittance advices (ERAs) and electronic funds transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, see **Chapter 1** under **Online resources**.

For further information about EDI online, go to **UHCprovider.com/resourcelibrary** to find **Electronic Data Interchange** menu.

Electronic payment solution: Optum Pay

UnitedHealthcare Community Plan sends electronic care provider payments instead of paper checks. You can sign up for automated clearinghouse (ACH)/direct deposit, our preferred method of payment, or to receive a virtual card payment. The only alternative to a virtual card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose automated clearinghouse/ direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean for you?

- If your practice/health care organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a virtual card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/health care organization is already enrolled and receiving your claim payments through ACH/direct deposit from Optum Pay™ or receiving virtual cards, you don't need to take action
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and virtual card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

All regulated entities have a Management Agreement with UnitedHealthcare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com/resourcelibrary**, to find the **EDI** section.

Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

Bill all hospital inpatient, outpatient and ER services using revenue codes and the UB-04 claim form:

- Include ICD-10-CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

Capitated services

Capitation is a payment arrangement for care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether or not that person seeks care. In most instances, the capitated care provider is either a medical group or an independent practice association (IPA). In a few instances, however, the capitated care provider may be an ancillary care provider or hospital.

We use the term "medical group/IPA" interchangeably with the term "capitated care providers." Capitation payment arrangements apply to participating physicians, care providers, facilities and ancillary care providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member.
2. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their delegation grids within their participation agreements to determine which delegated activities the capitated care providers are performing on behalf of UnitedHealthcare Community Plan.

For capitated services, include all services related to an inpatient stay on the UB-04 when a member is admitted to the hospital, they received ER treatment, observation or other outpatient hospital services.

We deny claims submitted with service dates that don't match the itemization and medical records. This is a billing error denial.

Form reminders

- Note the attending care provider name and identifiers for the member's medical care and treatment on institutional claims for services other than nonscheduled transportation claims
- Send the referring care provider NPI and name on outpatient claims when this care provider is not the attending care provider
- Include the attending care provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefits

Our benefits contracts are subject to subrogation and coordination of benefits (COB) rules:

- **Subrogation**
  We may recover benefits paid for a member's treatment when a third party causes the injury or illness
- **COB**
  We coordinate benefits based on the member's benefit contract and applicable regulations

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's explanation of benefits (EOB) or remittance advice with the claim.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services on a CMS 1500. Place the servicing care provider's name in box 31 and the servicing care provider's group NPI number in box 33a.

Global days

Global days include the billable period involving pre-operative visits, the procedure itself and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC) or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on **UHCprovider.com**/policies > For Community Plans > **Reimbursement Policies for Community Plan** > Global Days Policy, Professional-Reimbursement Policy-UnitedHealthcare Community Plan.

National Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the National Correct Coding Initiative (NCCI) and other nationally recognized sources.

Comprehensive and component codes

Comprehensive and component code combination edits apply when a code pair(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- **Separate procedures**
  Only report these codes when performed independently
- **Most extensive procedures**
  You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services**
  Don't report combinations where 1 code includes and the other excludes certain services
- **Medical practice standards**
  Services part of a larger procedure are bundled
- **Laboratory panels**
  Don't report individual components of panels or multichannel tests separately

Clinical Laboratory Improvements Amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office:
Phone: 1-505-222-8646
Email: CLIA.DHI@state.nm.us
Website: nmhealth.org/about/dhi/hflc/prop/clia or go to cms.gov.

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units
- The total bill charge is the unit charge multiplied by the number of units

Billing guidelines for obstetrical services

Follow this reporting procedure when submitting obstetrical delivery claims. Otherwise, we will deny the claim:

- If billing for both delivery and prenatal care, use the date of delivery
- Use 1 unit with the appropriate charge in the charge column

Billing guidelines for transplants

The New Mexico state department covers medically necessary, nonexperimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Ambulance claims (emergency)

Ambulance claims must include the point of origin, destination address, city, state and ZIP.

National drug code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed
- HCPCS/CPT code and units of service for the drug billed
- Actual metric decimal quantity administered

Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11-digit NDC code, unit/basis of measurement qualified and metric decimal quantity administered. Include HCPCS/CPT codes.

Care providers are required to report the "JW" and "JZ" modifier on claims that bill for drugs being supplied in a single-dose container or package based on FDA-approved labeling and will not be accepted for drugs that are from multiple-dose containers.

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See **Chapter 4** for more information about medical necessity.

Place of Service codes

Go to cms.gov for Place of Service codes.

Asking about a claim

You can ask about claims through Provider Services and the **UnitedHealthcare Provider Portal**.

Provider Services

Call **1-888-702-2202**. Have the following information ready before you call:

- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern.

UnitedHealthcare Provider Portal

Go to **UHCprovider.com** and sign in to view your claims transactions.

Resolving claim issues

View the **appeals and grievances grid** for submission information.

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and adjustment requests.

For paper claims

Submit a screenshot from your accounting software that shows when you submitted the claim. The screenshot must show the correct:

- Member name
- Date of service
- Claim date submission (within the timely filing period)

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier
- Another carrier's EOB
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If we reject a claim and don't receive corrections within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Timely filing limits can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement.

Balance billing

Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ
- We deny a claim for late submission, unauthorized service or as not medically necessary
- UnitedHealthcare Community Plan is reviewing a claim

You may balance bill the member for noncovered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate.

If you have questions, please contact your provider advocate. If you don't know who your provider advocate is, connect with a live advocate via chat on **UHCprovider.com/chat**, available 7 a.m.- 7 p.m. CT.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an EOB from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, you may submit the claim to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

COVID-19

UnitedHealthcare Community Plan of New Mexico abides by Healthcare Authority (HCA) standards for billing and payment of COVID-19 claims. Additional details can be found in our COVID-19 Billing Guidance **https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-claims.html** > billing guidelines > UHCCP-NM-covid-billing-guidance.pdf.

Gross receipt taxes

Effective Jan. 1, 2026, New Mexico Senate Bill 249 requires MCOs to provide visibility into the gross receipt taxes (GRT) reimbursement they've paid health care providers for Medicaid services they deliver to that MCO's members. Exceptions to this requirement are some non-profit providers and claim reimbursements for pharmaceuticals, durable medical equipment and certain non-taxable medical codes.

UnitedHealthcare will show GRT and service payments in separate, itemized lines on provider remittance advice notices.

Contract updates

UnitedHealthcare is revising provider agreements to pay GRT at rates determined by the New Mexico Taxation and Revenue Department. The state bases their rates according to its https://www.tax.newmexico.gov/all-nm-taxes/current-historic-tax-rates-overview/gross-receipts-tax-rates/.

Chapter 12: Claim reconsiderations, appeals, and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

The following grid lists the types of disputes and processes that apply:

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for submission	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim correction (resubmission)	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 31348 Salt Lake City, UT 84131-0348	**UHCprovider.com**	**1-888-702-2202**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations.**	90 calendar days.	30 calendar days.
Care provider claim reconsideration (step 1 of dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care provider		**UHCprovider.com**	**1-877-702-2202**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations.** For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide**.	90 calendar days.	30 calendar days.
Care provider claim formal appeal (step 2 of dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care provider			**1-888-702-2202**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations.** For further information on appeals, see the **Reconsiderations and Appeals interactive guide**.	60 calendar days from date of occurrence.	30 calendar days.
Care provider grievance	A grievance expressing dissatisfaction with operations, activities, provider payment issues, including Claims disputes, and/or Utilization Management decisions.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 31348 Salt Lake City, UT 84131-0348		**1-888-702-2202**	**UHCprovider.com/nmcommunityplan**	90 calendar days from date of occurrence.	30 calendar day. Standard grievance acknowledgment letter sent within 5 calendar days.

Appeals and grievances standard definitions and process requirements								
Situation	**Definition**	**Who may submit?**	**Submission address**	**Online form for mail**	**Contact phone number**	**Website (care providers only) for submission**	**Care provider filing time frame**	**UnitedHealthcare Community Plan response time frame**
Care provider appeal on behalf of member	A request to change an adverse benefit determination that we made.	• Member • Member's authorized representative (such as friend or family member) with written member consent • Care provider on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 31348 Salt Lake City, UT 84131-0348	**providerforms.uhc.com/ProviderAppealsandGrievance.html** • AOR Consent Form on this site for member appeals	**1-877-236-0826**	Use Prior Authorization on the UnitedHealthcare Provider Portal. **UHCprovider.com**, then Sign In on top right.	60 calendar days from denial date.	Urgent appeals: We will resolve within 72 hours. Standard appeals acknowledgment letter sent within 5 business days. Resolution of standard appeal within 30 calendar days.
Care provider grievance on behalf of member	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Care provider or authorized representative (such as friend or family member) on behalf of a member with member's written consent	**UnitedHealthcare Community Plan** P.O. Box 31348 Salt Lake City, UT 84131-0348		**1-877-236-0826**	**UHCprovider.com/nmcommunityplan**		Urgent appeals: We will resolve within 72 hours. Standard appeals acknowledgment letter sent within 5 business days. Resolution of standard appeal within 30 calendar day.

These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within care provider contracts than described in the standard process.

Denial

Your claim may be denied for administrative or medical necessity reasons.

- **Administrative denial**
  When we didn't get notification before the service, or the notification came in too late
- **Medical necessity**
  The level of care billed wasn't approved as medically necessary

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

- **Duplicate claim**
  One of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.
- **Claim lacks information**
  Basic information is missing, such as a person's date of birth; or information is incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.
- **Eligibility expired**
  Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired, and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.
- **Claim not covered by UnitedHealthcare Community Plan**
  Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.
- **Time limit expired**
  This is when you don't send the claim in time

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

View the **appeals and grievances grid** for submission information.

For those care providers exempted from this requirement, you may submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 31348
Salt Lake City, UT 84131-0348

Additional information

- When correcting or submitting late charges on 837 institutional claims, use bill type xx7: Replacement of Prior Claim
- Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim
- To void a claim, use bill type xx8

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal – the claim needs to be corrected through resubmission.

Common reasons for rejected claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address
- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number

How to use:

To resubmit the claim, follow the same submission instructions as a new claim.

View the **appeals and grievances grid** for submission information.

Claim reconsideration (step 1 of dispute)

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly. When you send a reconsideration, please send additional support information.

When to use:

Reconsiderations can be done repeatedly but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials – In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials –

- In your request, please include any additional clinical information that may not have been reviewed with your original claim
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation

How to use:

View the **appeals and grievances grid** for submission information.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-888-702-2202** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why. Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service.

It includes:

- A denial or rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

View the **appeals and grievances grid** for submission information.

Submit a screenshot from your accounting software that shows the date you submitted the claim. The screenshot must show:

- Correct member name
- Correct date of service
- Claim submission date

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments based on our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an overpayment return check or the Overpayment Refund/Notification form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions
- Member identification number
- Date of service
- Original claim number (if known)
- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

Where to send:

Mail refunds with an overpayment return check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
Attn: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com/claims**.

If you do not agree with the overpayment findings, submit a dispute within the required time frame as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See **Dispute** section in this chapter.

We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or provider remittance advice (PRA). When additional information is needed, we will ask you to provide it.

Any overpayments not self-reported within 60 calendar days may be considered false claims and subject to referral as a credible allegation of fraud (section 4.18.3.3.1 of the contract would apply).

Sample overpayment report

***The information provided is sample data only for illustrative purposes.
Please populate and return with the data relevant to your claims that have been overpaid.**

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim.
2222222	02/02/24	14A000000002	03/15/24	$77.29	$27.29	Contract states $50.00, claim paid $77.29.
3333333	03/03/24	14A000000003	04/01/24	$131.41	$98.56	You paid 4 units, we billed only 1.
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance.
55555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated.

Appeals (step 2 of dispute)

What is it?

An appeal is a review of a reconsideration claim. It is a one-time formal review of a processed claim that was partially paid or denied.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information.

View the **appeals and grievances grid** for submission information.

Questions about your appeal or need a status update?

Call **Provider Services** at **1-888-702-2202** for questions about your appeal or if you need a status update. If you filed your appeal online, you should receive a confirmation email or feedback through the secure UnitedHealthcare Provider Portal.

Care provider grievance

What is it?

Grievances are issues or problems related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits and limitations
- Care provider payment issues, including claims disputes and/or utilization management decisions
- Eligibility and enrollment of a member or care provider
- Member issues or UnitedHealthcare Community Plan issues
- Availability of health services from UnitedHealthcare Community Plan to a member
- The delivery of health services
- The quality of service

How to file:

View the **appeals and grievances grid** for submission information.

You may only file a grievance on a member's behalf with the written consent of the member.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses CMS definitions for appeals and grievances.

Care provider appeal on behalf of member

What is it?

An appeal is a formal way to share dissatisfaction with a benefit determination.

You, with a member's written consent, or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service
- Refuses, in whole or part, payment for services
- Fails to provide services in a timely manner, as defined by the state or CMS
- Doesn't act within the time frame CMS or the state requires

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

View the **appeals and grievances grid** for submission information.

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at **providerforms.uhc.com**.

How to use:

Whenever we deny a service, you must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision
- Present evidence, and allegations of fact or law, in person and in writing
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal
- Ask for an expedited appeal if waiting for this health service could harm the member's health
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard appeal 30 calendar days from the day we receive it. We resolve an expedited appeal 72 hours from when we receive it. We may extend the response up to 14 calendar days if the following conditions apply:

1. Member requests we take longer.
2. We request additional information and explain how the delay is in the member's interest.

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at **providerforms.uhc.com**.

If needed, an appeals representative will provide you with this form. Expedited appeals do not need to be in writing.

Care provider grievance on behalf of member

What is it?

A grievance is an expression of dissatisfaction about UnitedHealthcare Community Plan and/or a care provider about any matter other than an adverse benefit determination. This includes quality of care or service concerns and aspects of interpersonal relationships, such as a care provider or employee's rudeness.

When to use:

You may act on the member's behalf with their written consent.

Where to send:

View the **appeals and grievances grid** for submission information.

We will send an answer no longer than 90 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires

Email: **UHCCP_NM_AG@uhc.com**

As the care provider, you may also submit electronically on **UHCprovider.com/nmcommunityplan** and navigate to Prior Authorization to submit a grievance on a member's behalf.

We will send an answer no longer than 30 calendar days from when you filed the grievance or as quickly as the member's health condition requires.

Care provider state fair hearing on behalf of member

What is it?

A state fair hearing lets members share why they think New Mexico Medicaid services should not have been denied, reduced or terminated.

When to use:

They must exhaust the health plan's appeal process before requesting a state fair hearing.

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

You or the member have 90 calendar days (standard appeals) or 30 calendar days (quick appeals) from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by calling or writing to:

Ste of NM HSD - Office of Fair Hearings
37 Plaza La Prensa
PO Box 2348
Santa Fe, NM 87504

Phone – 1-800-432-6217, press option 6 or 1-505-476-6213

Fax: 1-505-476-6215

Email: HSD-FairHearings@state.nm.us

- The member may ask UnitedHealthcare Community Plan Member Services for help writing the letter
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.
- The member may ask for continuation of services during the state fair hearing. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.

Processes related to reversal of our initial decision

If the state fair hearing outcome is to not deny, limit or delay services while the member is waiting on an appeal, then we provide the services:

1. As quickly as the member's health condition requires.
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the state fair hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Chapter 13: Fraud, waste, and abuse

UnitedHealthcare Community Plan's anti-fraud, waste and abuse efforts focus on prevention, detection and investigation of false and abusive acts committed by you and plan members. The effort also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies based on state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its work. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners.

This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the compliance program is reviewing our operation's high-risk areas through the implementation of reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find out how we follow federal and state regulations around false claims at **UHCprovider.com/nmcommunityplan** > Integrity of Claims, Reports, and Representations to the Government.

Fraud, waste and abuse definitions

- **Abuse by a care provider:**

Care provider practices that are inconsistent with sound fiscal, business or medical practices that result in an unnecessary cost to the program or in reimbursement for services not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the program.

- **Fraud by a member or care provider:**

Intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or state law.

- **Waste by a care provider:**

Incurring unnecessary costs as a result of deficient management, practices or controls. Overuse of services that result in unnecessary costs to the Medicaid program. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Care provider fraud, waste, and abuse requirements and responsibilities

Care providers who furnish services to Medicaid members agree to comply with all federal and state laws and regulations related to the provision of medical services. This includes, but is not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, HIPAA and the state Medicaid Fraud Act. You also agree to conform to the NM Health Care Authority policies and instructions as specified in this manual and its appendices, including any updates.

Deficit Reduction Act

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors.

They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Policies and procedures

Establish written policies and procedures for all employees, agents or contractors that provide detailed information about the Federal False Claims Act established under 31 USC §3729-3733 and whistleblower protection/non-retaliation information. This includes preventing and detecting FWA in federal health care programs (as defined in the Social Security Act §1128B(f)).

Audits, reviews and investigations

You are required, upon request, to make available to UnitedHealthcare and/or a recovery audit contractor (RAC), or other designated entity, any and all administrative, financial and medical records relating to the delivery of items or services for which state monies are expended unless otherwise provided by law. In addition, you are required to provide access during normal business hours to its respective place of business and records.

Claims and fraud, waste, and abuse

According to your provider agreements with UnitedHealthcare Community Plan and contract(s) with the NM Health Care Authority, you must:

- Abide by all laws, rules and regulations related to providing Medicaid-covered services; and
- Assume full responsibility for the claims you submit for services provided under Medicaid, which includes any and all claims submitted under your NPI, on your behalf, by an employee, or third-party billing contractor.

You have legal and contractual obligations to ensure the claims you submit are accurately coded based on the most recent updates and changes to the coding rules and guidelines.

In some cases, failing to do so may result in administrative actions, including, but not limited to, recoupment of payments, being required to provide documented proof of services before payment, or termination from the network if fraud is identified. Potential civil or criminal prosecutions may arise as a result of findings of fraud.

Reporting fraud, waste, and abuse

You are required to report any known or suspected cases of fraud and abuse to UnitedHealthcare Community Plan either online at: **uhc.com/fraud** or by phone: **1-844-359-7736**.

Resources

To learn more about detection and prevention of fraud, visit the following:

- **Fraud, Waste and Abuse Provider Training - UnitedHealthcare Community Plan of New Mexico**. Click on "State Specific Training," and select "New Mexico. You can also access this training via web on the Provider's UnitedHealthcare Community Plan of NM Homepage under "Provider Training" and by selecting "Additional Training and Resources.
- HHS Office of Inspector General's website at oig.hhs.gov/fraud for information on detection and prevention of fraud.
- You can also visit: **uhc.com/fraud** or CMS.hhs.gov/FraudAbuseforProfs/

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month.

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 OIG List of Excluded Individuals and Entities (LEIE)
- General Services Administration (GSA) System for Award Management

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Self-report overpayments

Providers are required to report identified overpayments to UnitedHealthcare by the later of:

1. The date which is 60 calendar days after the date on which the overpayment was identified; or
2. The date any corresponding cost report is due, if applicable.

A care provider has identified an overpayment if the provider has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference that an overpayment exists.

Overpayments that have been identified by a provider and not self-reported within the 60 calendar day time frame may be considered false claims and subject to referrals as credible allegations of fraud.

Self-reported overpayments must be sent to UnitedHealthcare with the following information included:

- Provider's name
- Tax identification number and National Provider Number
- How the overpayment was discovered
- The reason for the overpayment
- The health insurance claim number, as appropriate
- Date(s) of service
- Medicaid claim control number, as appropriate
- Description of corrective measures taken to prevent re-occurrence or an explanation of why corrective measures are not indicated
- Whether the provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under OIG Self-Disclosure Protocol
- Specific dates (or time-span) within which the problem existed that caused the overpayment
- Whether a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment
- The refund amount, provided, however, that related overpayments may be reported on a single Overpayment Report

Chapter 14: Care provider communications and outreach

Key contacts

Topic	Link
Provider education	**UHCprovider.com/resourcelibrary**
News and bulletins	**UHCprovider.com/news**
Care provider manuals	**UHCprovider.com/guides**

Communication with care providers

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **Chat support available**
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**. Available Monday-Friday, 7 a.m.–7 p.m. CT, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **UHCprovider.com**
  This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates and quality programs.
- **UHCprovider.com/nmcommunityplan**
  The UnitedHealthcare Community Plan of New Mexico page has state-specific resources, guidance and rules
- **Policies and protocols**
  UHCprovider.com/policies > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (Twitter)
- **New Mexico health plans**
  UHCprovider.com is the fastest way to review all of the health plans UnitedHealthcare offers in New Mexico. To review information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  - You can learn more about the portal in **Chapter 1** of this care provider manual or by visiting **UHCprovider.com/portal**.

  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.
  - Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal**.
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution. If you are not sure who your provider advocate is, you can view a map to determine which provider advocate to contact based on your location at **UHCprovider.com/nmcommunityplan** > Contact Us.

Care provider training and education

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Care provider manual

UnitedHealthcare Community Plan publishes this care provider manual online. It includes an overview of the program, a toll-free number for **Provider Services** at **1-888-702-2202** and a list of additional care provider resources. You can request a hard copy of this manual by contacting Provider Services.

State websites and forms

Find the following forms on the state's website at **UHCprovider.com/nmcommunityplan**:

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form
- Provider Service Agreement (MC 19 Form)

Appendix 1: Alternative benefit plan coverage

Exhibit A: Coverage under alternative benefit plan

- Allergy testing and injections
- Annual physical exam and consultation[1]
- Applied Behavior Analysis (ABA)
- Bariatric surgery[2]
- Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
- Cancer clinical trials
- Cardiovascular rehabilitation[3]
- Chemotherapy
- Chronic Care Management services
- Dental services[4]
- Diabetes treatment, including diabetic shoes, medical supplies, equipment and education
- Dialysis
- Diagnostic imaging
- Disease management
- Drug/alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services
- Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement[5]
- Electroconvulsive therapy
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including routine oral and vision care, for individuals ages 19 to 20
- Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care
- Family planning and reproductive health services and devices, sterilization, pregnancy termination, contraceptives, and insertion and/or removal of contraceptive devices[6]
- Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services
- Genetic evaluation and testing[7]
- Habilitative and rehabilitative services, including physical, speech and occupational therapy[8]
- Hearing screening as part of a routine health exam[9]
- Holter monitors and cardiac event monitors
- Home health care, skilled nursing and intravenous services[10]
- Hospice care services
- Immunizations[11]
- Inpatient physical and behavioral health hospital/medical services and surgical care[12]
- Inpatient rehabilitative services facilities[13]
- Internal prosthetics

Exhibit A: Coverage under alternative benefit plan, continued

- IV infusions
- Lab tests, X-ray services and pathology
- Maternity care, including delivery and inpatient maternity services, non-hospital births, and pre- and post-natal care
- Medication-assisted therapy for opioid addiction
- Non-emergency transportation when necessary to secure covered medical services
- Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity
- Organ and tissue transplant[14]
- Osteoporosis diagnosis, treatment and management
- Outpatient surgery
- Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions[15]
- Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol and other preventive/diagnostic care and screenings[16]
- Physician visits
- Podiatry and routine foot care[17]
- Prescription medicines
- Primary care to treat illness/injury and chronic disease management
- Pulmonary therapy[18]
- Radiation therapy
- Reconstructive surgery for the correction of disorders that result from accidental injury, congenital
- Defects or disease
- Skilled nursing[19]
- Sleep studies[20]
- Specialist visits
- Specialized Behavioral Health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)[21]
- Telemedicine services
- Tobacco cessation treatment and services (may include counseling, prescription medications, and products)
- Transitional Care Management services
- Urgent care services/facilities
- Vision care for eye injury or disease[22]
- Vision hardware (eyeglasses or contact lenses)[23]

Exhibit A: Footnotes

[1] Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.

[2] Limited to 1 per lifetime. Criteria may be applied that consider previous attempts by the member to lose weight BMI and health status.

[3] Limited to short-term therapy (2 consecutive months) per cardiac event.

[4] The ABP covers dental services for adults in accordance with NMAC 8.310.2. Recipients ages 19–20 may receive dental services according to the increased periodicity schedule under EPSDT.

[5] Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.

[6] Sterilization reversal is not covered. Infertility treatment is not covered.

[7] Limited to genetic testing outlined in NMAC 8.3.10.2. Does not include random genetic screening.

[8] Limited to short-term therapy (2 consecutive months) per condition.

[9] Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for members ages 19–20. The ABP does not cover audiology services.

[10] Home health care is limited to 100 visits per year. A visit cannot exceed 4 hours.

[11] Includes ACIP-recommended vaccines.

[12] Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. Surgeries for cosmetic purposes are not covered.

[13] Includes services in a nursing or long-term acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the member is the eventual return home.

[14] Transplants are limited to 2 per lifetime.

[15] Other over-the-counter items may be considered for coverage only when the items are considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.

[16] Includes US Preventive Services Task Force "A" and "B" recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine.

[17] Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

[18] Limited to short-term therapy (2 consecutive months) per condition.

[19] Subject to the 100-visit home health limit when provided through a home health agency.

[20] Limited to diagnostic sleep studies performed by certified providers/facilities.

[21] The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite Services.

[22] Refraction for visual acuity and routine vision care are not covered, except for members ages 19–20.

[23] Covered only following the removal of the lens from 1 or both eyes (aphakia). Coverage of materials is limited to 1 set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware and routine vision care are covered for recipients ages 19–20 following a periodicity schedule.

Exhibit B: Coverage under agency-based community benefit

- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications ($5,000 limit every 5 years)
- Home Health Aide
- Nutritional Counseling
- Personal Care Services (Consumer Directed and Consumer Delegated)
- Private Duty Nursing for Adults
- Respite (annual limits may apply)
- Skilled Maintenance Therapy Services

Exhibit C: Coverage under self-directed community benefit

- Behavior Support Consultation
- Customized Community Support
- Emergency Response
- Employment Supports
- Environmental Modifications ($5,000 limit every 5 years)
- Home Health Aide
- Self-Directed Personal Care (formerly Homemaker)
- Start-Up Goods (For member electing SDCB on or after January 1, 2019, one-time limit of $2,000)
- Nutritional Counseling
- Private Duty Nursing for Adults
- Related Goods (annual limits may apply)
- Respite (annual limits may apply)
- Skilled Maintenance Therapy Services
- Specialized Therapies (annual limits may apply)
- Transportation (non-medical) (annual limits may apply)