



truehealth[™]
new mexico



True Health New Mexico Provider Handbook

True Health New Mexico
P.O. Box 37200
Albuquerque, NM 87176

Customer Service: 1-844-508-4677

truehealthnewmexico.com



Table of Contents (click on headings below to jump to section)

INTRODUCTION.....	3
PURPOSE	4
CONTACT INFORMATION.....	5
PROVIDER RESOURCES.....	6
QUALITY PROGRAM	7
FRAUD, WASTE, AND ABUSE.....	9
CREDENTIALING AND RE-CREDENTIALING.....	11
PROVIDER ROLES AND RESPONSIBILITIES.....	13
MEDICAL MANAGEMENT.....	18
CASE MANAGEMENT	20
PHARMACY.....	25
ADDITIONAL INFORMATION	28
AUTHORIZATIONS	31
REIMBURSEMENT POLICY	35
CLAIMS SUBMISSION AND PAYMENT	40
PROVIDER APPEALS AND GRIEVANCES.....	47
MEMBER COMPLAINTS AND APPEALS.....	50
MEMBER RIGHTS AND RESPONSIBILITIES.....	51
ACCESSING THE TRUE HEALTH NEW MEXICO PROVIDER DIRECTORY.....	56
NOTICE OF PRIVACY PRACTICES.....	60
LINKS TO IMPORTANT FORMS & OTHER RESOURCES	65
HMO PLANS: SMALL AND LARGE GROUP ID CARD SAMPLE.....	66
PPO PLANS: SMALL AND LARGE GROUP ID CARD SAMPLE	67
FEDERAL PLAN SAMPLE ID CARD	68
Appendix	69



INTRODUCTION

True Health New Mexico is a physician-led health plan and is committed to providing the highest quality care to its members. True Health is dedicated to driving improvements in quality on a broader scale in the community. The vision of True Health New Mexico is to bring a life-improving revolution in health to New Mexicans through partnerships with its members, providers and the community at large.

True Health New Mexico is a Bright HealthCare company. You can find more information about Bright HealthCare at <https://brighthousecare.com/>.

True Health New Mexico drives implementation of integrated care and payment models, producing improved health outcomes while “bending the cost curve,” if not actually lowering aggregate costs. True Health New Mexico understands the importance of building programs that will influence its members’ health behaviors, resulting in positive, sustainable health outcomes. In partnership with its members, providers, and communities, True Health New Mexico seeks to ensure a clinically integrated approach to improving health care quality and access to quality care throughout the state of New Mexico.

This handbook is an important part of the participating providers’ Contractual Agreement with True Health New Mexico and is intended to provide True Health New Mexico network practitioners, staff, and the larger health care delivery system the information, tools, and guidance needed to facilitate care and services for True Health New Mexico members.

Learn more about True Health New Mexico at truehealthnewmexico.com.



PURPOSE

This handbook is intended to provide a general overview of the True Health New Mexico functional areas, processes and requirements. True Health New Mexico is committed to providing timely and accurate updates to the Provider Network. However, there may be times when new procedures are implemented and not immediately reflected in the handbook.

CONTACT INFORMATION

Department	Phone	Fax	Link to Web
Provider Contracting	844-508-4677	866-311-7044	Provider Contracting
Provider Credentialing	844-508-4677	888-282-3483	Provider Handbook
Medical Management	844-508-4677	866-628-3047	Provider Handbook
Prior, Concurrent and Expedited Medical Authorizations	844-508-4677	866-628-3047	Prior Authorization Requests
Pharmacy Prior, Concurrent and Expedited Medication Authorizations	866-823-1606	866-718-7938	Pharmacy Services
Customer Care	844-508-4677	312-548-9943	Contact Us Page
Albuquerque Public Schools Customer Care	877-210-8339	312-548-9943	APS Page
Provider Appeals & Grievances	800-747-9132	800-747-9132	Provider Handbook
Compliance Hotline	855-208-3766	N/A	Contact Us Page
Fraud, Waste & Abuse Hotline	855-822-3903	866-231-1344	Contact Us Page
TTY Services	800-659-8331	N/A	Contact Us Page



PROVIDER RESOURCES

Language Line

True Health New Mexico offers translation and interpretation services in Spanish, Navajo/Diné, and more than 200 other languages. If the member requires translation or interpretation services during a visit, please contact the Customer Care Center, toll-free, at 1-844-508-4677 for assistance.

Provider Newsletter

Four times a year, True Health New Mexico shares important news, updates, and information that affects participating providers and members through the provider newsletter, ***True Health New Mexico Provider Connection***. The newsletter is sent via email in March, June, September and December, and is also posted to the Provider Forms and Other Resources section of the True Health New Mexico website. Please go to truehealthnewmexico.com/provider-forms-and-other-resources/ for more information.

If you do not receive the quarterly newsletter and would like to, please email provider.newsletter@truehealthnewmexico.com or contact your dedicated Provider Services Representative. Please include your name and the name of your practice in your request.



QUALITY PROGRAM

The goal of the True Health New Mexico Quality Improvement Program (QIP) is to develop, implement, and maintain a quality program that meets the unique and diverse needs of its membership, New Mexico communities, and of the health care delivery system. The program's intent is to deliver care that exceeds expectations, promotes innovation in reimbursement strategies and opportunities to change health behaviors, and incorporates highly integrated clinical care approaches to improve health outcomes.

Implementation of True Health New Mexico's quality plan supports service delivery, quality health care, and member/patient safety. The promotion of quality, enabled, and sustained through the creation of appropriate infrastructure, requires the following:

- Ensuring Qualified Health Plan (QHP) and National Committee for Quality Assurance (NCQA) Accreditation status.
- Ensuring compliance with ACA and state regulations, rules, and legislation.
- Developing an integrated set of core services, programs, and interventions to improve health outcomes of members while actively engaging providers.
- Developing effective monitoring and evaluation programs of health care services to meet or exceed current standards while identifying opportunities for continuous improvement and subsequent implementation of solutions.
- Developing effective processes and educational opportunities to reduce medical errors and improve patient safety.
- Identifying and responding to health care disparity issues to improve quality of care.
- Developing and implementing programs in alignment with ACA.
- Implementing and evaluating the quality improvement program and activities to be aligned with the National Strategy for Quality Improvement in Health Care.

The True Health New Mexico QIP activities are integrated within all health plan operations and provide mechanisms for the coordination of quality improvement, medical and behavioral health management, member services, and all essential plan functions that contribute to the quality of member care, services, and experience. The QIP is reflective of the local health care delivery system and provides for a systematic approach to continuous improvement, encompassing the quality of evaluation and improvement activities across the continuum of health care services that impact members and providers.

The following program components are essential in the promotion of quality health care delivery and plan services and are covered as part of the QI Program:

Service Quality

- Complaints and Appeals Processes
- Member Satisfaction (CAHPS®, Qualifying Health Plan [QHP] Enrollee Experience Survey, and other)
- Customer (member, producer, practitioner/provider, employer) Communications



- Member Services

Integrated Clinical Management

- Disease Management/Chronic Condition Management/Complex Case Management
- Community Health Worker Program
- Utilization Management
- Pharmacy and Therapeutics
- New Technology Evaluation

Population Health

- HEDIS® Measurement Set
- CMS Quality Rating System
- Continuity and Coordination of Care (Medical and Behavioral)
- Culturally and Linguistically Appropriate Services
- Wellness and Health Promotion
- Patient Safety

Provider Network

- Network Management and Credentialing/Re-credentialing
- Provider/Practitioner Satisfaction
- Contracting: Provider/Practitioner
- Accessibility and Availability

Plus:

- Delegation of some internal processes
- NCQA Accreditation
- QHP and Exchange Requirements



FRAUD, WASTE, AND ABUSE

True Health New Mexico's Fraud, Waste, and Abuse Program is overseen by the True Health New Mexico Operations/Compliance Department. True Health New Mexico utilizes the Fraud, Waste, and Abuse monitoring services of ClarisHealth to audit claims.

The Program seeks to:

- Prevent, detect, and investigate all forms of health insurance fraud;
- Educate appropriate employees and other persons on fraud detection and the Company's anti-fraud plan;
- Cover reports of insurance fraud to appropriate law enforcement and regulatory authorities; and
- Pursue restitution, where appropriate, for financial loss caused by insurance fraud.

Definitions

Fraud is defined as "any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or him/her or some other person in a managed care setting." It includes any act that constitutes fraud under applicable federal or state law.

Fraud may be found under the following conditions (the following list is intended as an example and not as a limitation):

- When a provider submits a bill for a service that was not provided; or
- When a provider bills for a time period greater than the time actually spent with the client; or
- When a provider bills for the provision of a service that did not meet the service definitions, performance specifications, state or federal regulations, or accreditation standards customarily recognized in behavioral health care; or
- Inappropriate or frequent referrals that may constitute a conflict of interest; or
- Authorizations for services to providers who may have personal or other financial relationships with care managers; or
- Other related claims or care management issues that may involve intentional deception or misrepresentation as referenced above.

Waste is defined by the Office of Inspector General as the intentional or unintentional, thoughtless or careless expenditure, consumption mismanagement, use, or squandering of government resources to the detriment or potential detriment of government programs. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse is defined as "any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to True Health New Mexico, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized



standards or contractual obligations for health care in a managed care setting.” It also includes recipient practices that result in unnecessary cost to True Health New Mexico.

- **Examples:** Altering claims, double billing, billing for services not provided, over-utilization; kickbacks, using fraudulent credentials and pharmacies billing for brand when generic drugs are dispensed.

Federal and State Statutes and Regulations Applicable to True Health New Mexico Providers:

- The New Mexico Insurance Fraud Act (59A-16C NMSA)
- The False Claims Act (31 U.S.C. 3729-3733)
- The Anti-Kickback Statute (42 U.S.C. 1320a-7b(b) and 42 C.F.R. 1001.952)
- The Physician Self-Referral Law (42 U.S.C. 1395nn and 42 C.F.R. 411.350)
- The Exclusion Authorities (42 U.S.C. 1320a-7; 1320c-5 and 42 C.F.R. 1001 and 1002)
- The Civil Monetary Penalties Law (42 U.S.C. 1320a – 7a and 42 C.F.R. 1003)
- The Health Care Fraud Statute (18 U.S.C. 1347 and 1349)
- The Patient Protection and Affordable Care Act

Reporting Potential Fraud, Waste, and Abuse and Other Suspicious Activity

Reports are confidential. When reporting suspicious behavior, you may remain anonymous. To report:

- Contact our Fraud, Waste, and Abuse hotline: 1-855-208-3766
- Email: Reports@Lighthouse-Services.com.
- Online: <https://www.lighthouse-services.com/brighthealthgroup>



CREDENTIALING AND RE-CREDENTIALING

True Health New Mexico is dedicated to providing its members with access to effective, high-quality, affordable health care. In order to ensure True Health New Mexico maintains the highest integrity throughout the provider network, True Health New Mexico verifies and reviews the credentials of its participating practitioners and facilities. True Health New Mexico credentials providers and facilities after the initial contract is agreed upon, and re-credentials participating providers every three years. This process ensures True Health New Mexico maintains and improves the quality of care and services delivered to its members.

True Health New Mexico's credentialing processes and standards have been designed to be consistent with broadly adopted standards, including NCQA and New Mexico statutory and regulatory requirements.

True Health New Mexico prefers that physicians that wish to participate in the True Health New Mexico network are board-certified or board-eligible in their area of specialty.

All practitioners that apply for participation in the True Health New Mexico network must meet, at a minimum, the following:

True Health New Mexico eligibility criteria for initial credentialing and for re-credentialing:

- Current, valid, and unrestricted medical license to practice in the state in which the practitioner will treat True Health New Mexico members.
- Prescribing practitioners must hold current and unrestricted Drug Enforcement Administration (DEA) registration and a current unrestricted state Controlled Dangerous Substance (CDS) certificate, if applicable, in the state in which the practitioner practices.
- If a prescribing practitioner does not prescribe medications, he or she must submit a written description of a formal arrangement for medication prescription for his or her patients should any of them require medication.
- Proof of successful completion and graduation from medical school or professional school.
- Physicians must successfully complete a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME).
- Non-physicians must have a master's degree, complete state mandated clinical hours, and certification, if applicable.
- Current professional liability (malpractice) insurance.
- Practitioners and physicians with hospital privileges must have clinical privileges in good standing at the facility designated by the practitioner as the primary admitting facility.
- If a practitioner does not have admitting privileges, he or she must submit a written description of a formal arrangement for inpatient coverage for his or her patients should any of them require hospitalization.



Credentialing Applications

True Health New Mexico prefers the CAQH Universal Provider DataSource (UPD) application for gathering data about practitioners initially, and then every three years thereafter for re-credentialing. Practitioners are encouraged to update their online CAQH applications prior to credentialing or re-credentialing with True Health New Mexico.

Credentialing/Contracting

Providers who have not completed the credentialing process and have not been approved by the True Health New Mexico Credentialing Committee are considered non-contracted, non-participating or “out of network” with True Health New Mexico. Claims for services rendered by non-credentialed, non-contracted providers may be denied payment, unless otherwise authorized by True Health New Mexico.

Practitioners must have in their possession a signed agreement and the credentialing approval letter to begin providing treatment to True Health New Mexico members. The initial credentialing approval letter will be sent by the True Health New Mexico Provider Contracting representative and confirmation of completed re-credentialing will be sent.

Practitioner Rights Related to the Credentialing Process

Under Section 13.10.28 of the New Mexico Administrative Code (NMAC), providers have rights that include but are not limited to the following:

- Timely credentialing decisions
- Reimbursement upon delay in the credentialing process
- Payment of overdue claims and payment of interest due to delay in credentialing decisions
- Payment dispute resolution

To initiate a payment dispute, contact True Health New Mexico in writing. We will respond to all disputes in writing within 15 days. The response shall include an explanation of failure or refusal to pay, and the expected date of payment, if payment is pending.

If True Health New Mexico fails to respond, or if there is a belief that payment is being denied, delayed, or calculated in error and the matter has not been successfully resolved at the internal level within 45 days, then a complaint may be filed, either individually or in batches, with the superintendent using the form found on the OSI website.

Physicians and other health care practitioners applying for participation in the True Health New Mexico provider network have the following rights regarding the credentialing process:

- The right to review the information submitted to support the credentialing application;
- The right to correct erroneous information; and
- The right to be informed of the status of the credentialing or re-credentialing application, upon request.



PROVIDER ROLES AND RESPONSIBILITIES

True Health New Mexico's philosophy is simple: Empower providers and give them the tools they need to properly care for True Health New Mexico members.

True Health New Mexico is a doctor-led organization that understands the challenges providers face. New Mexico is unique, and so are our health challenges. True Health New Mexico's goal is to ensure contracted providers are supported as they try to positively impact the health of their patients and the community. True Health New Mexico believes the relationship between providers and patients should be at the center of healthcare. True Health New Mexico's vision is to reward primary care for both improving the health outcomes of their patient population and reducing costs.

It is True Health New Mexico's intention to empower providers to coordinate the care of members and create patient-centered medical homes to not only drive down healthcare costs but to also improve health outcomes. Additionally, True Health New Mexico supports innovation and works with providers on pilot programs that aim to improve patient care and reduce costs. True Health New Mexico believes innovation comes from the ground up, and we are open and responsive to contracted providers' ideas about improving healthcare.

Primary Care Overview

True Health New Mexico values the relationship between a patient and their Primary Care Practitioner (PCP) and believes access to PCPs is critical for the overall well-being of its members. The PCP plays a critical role in care management and the success of members who are encouraged to be engaged in their own health care maintenance and wellness.

In True Health New Mexico's continuing efforts to offer affordable health care coverage, True Health New Mexico will work with its practitioners and members to avoid uncoordinated, episodic care by encouraging close relationships between the member and the PCP while offering readily accessible preventive health care services and treatment. True Health New Mexico will also ensure that members with chronic health care needs have the information they need to manage their conditions.

Primary Care Practitioner Selection

True Health New Mexico encourages members to select a PCP within 30-days of enrollment in a True Health New Mexico health plan. True Health New Mexico will monitor for members that have not selected a PCP and conduct an outreach to the member to encourage PCP selection as soon as possible. Members are encouraged to contact their intended PCP office and to establish with the PCP through a new patient visit.

True Health New Mexico's network of PCPs includes practitioners in the fields of family medicine, internal medicine, and pediatrics, including physician assistants and nurse practitioners practicing primarily in these areas of medicine. Other practitioners, such as



OB/GYNs, may be considered for designation as PCPs if their scope of practice includes all aspects of primary care and they elect to practice in the role of a PCP. PCP designation for other specialists must be approved by the True Health New Mexico Medical Director.

The member's PCP will **not** be indicated on his or her ID card. Validation of the member's eligibility can be completed through the Provider Portal, HealthXnet, or by calling Customer Care at 1-844-508-4677.

In-Network Specialists

Members may self-refer to in-network specialists. Prior authorization must be obtained from True Health New Mexico for services provided by non-contracted providers.

Referrals to In-Network Providers

Providers should always refer True Health New Mexico members to other in-network practitioners and facilities for care. Referring True Health New Mexico members to out-of-network providers often results in higher cost to the member and/or the out-of-network provider balance-billing the member/patient. Special care should be taken to ensure that True Health New Mexico members are referred to in-network laboratories, radiology centers, hospitals, and other providers. A complete list of in network providers can be found on True Health New Mexico's website at truehealthnewmexico.com. Click on "Find a Doctor" from the home page.

Specialty Care Practitioners

Specialty Care Practitioners are trained to provide services in specialized fields of medicine. In order to participate in the True Health New Mexico network, Specialty Care Practitioners must agree to accept patients from other in-network providers and to provide specialized services to the member.

Referrals to Out-of-Network Providers

In-Network providers should make best efforts to direct members to In-Network specialists. Authorizations for referrals to out-of-network providers must be obtained through True Health New Mexico and are subject to prior authorization requirements.



REFERRING TRUE HEALTH NEW MEXICO MEMBERS TO OUT-OF-NETWORK PROVIDERS ALWAYS REQUIRES PRIOR AUTHORIZATION FROM TRUE HEALTH NEW MEXICO.

Appointment Wait Times

- The wait time for an appointment with a Specialist shall not exceed four (4) weeks from the time of request.

- If provider is a PCP, they shall be available by telephone or by appointment 24-hours per day, 7-days per week to ensure timely evaluation of members’ health needs.
- If the provider is unavailable, it is the responsibility of the provider to arrange for coverage by a participating True Health New Mexico network provider. The provider shall ensure that its wait times for appointment do not exceed:
- Routine, non-emergent appointments shall be scheduled as soon as is practical to the needs of the member but in no case longer than thirty (30) business days from request.
- Routine physical exams shall not exceed a wait time of four (4) months.
- The wait time for urgent care appointments shall not exceed forty-eight hours.
- In non-emergency situations, the wait time in the provider’s office shall not exceed 30 minutes from the scheduled appointment time.

Responsibilities of **All** True Health New Mexico Providers



THE TABLES ON THE FOLLOWING PAGES OUTLINE THE RESPONSIBILITIES OF ALL TRUE HEALTH NEW MEXICO PARTICIPATING PROVIDERS, WHETHER PCP, SPECIALIST, OR BEHAVIORAL HEALTH.

Responsibility	PCP	Specialist	MH/BH
Meet True Health New Mexico’s credentialing and re-credentialing requirements.	X	X	X
Notify True Health New Mexico of changes that could affect the ability to effectively render medical care, including but not limited to changes in address, licensure, liability insurance coverage, and contracting status.	X	X	X
Refer to the True Health New Mexico provider contract for termination policies including time frame specifics and obligations.	X	X	X
Adhere to True Health New Mexico utilization and quality management procedures.	X	X	X
Follow True Health New Mexico’s administrative policies and procedures including compliance with all Health Insurance Portability and Accountability Act (HIPAA) regulations.	X	X	X
Adhere to True Health New Mexico prior authorization procedures and requirements.	X	X	X
Ensure continuity of care for members by coordinating all care, referrals, and follow-up treatment of members.	X		
Initiate referrals to in-network specialty care providers, hospitals, and facilities as clinically appropriate.	X	X	X

Responsibility	PCP	Specialist	MH/BH
Provide medically necessary services to members who have been referred by their PCP, another in-network health care practitioner, or who have self-referred appropriately for specific health concerns, diagnoses, and treatments.		X	X
Communicate with members, referring providers, and other in-network providers regarding services rendered, results, reports, and recommendations to ensure continuity and quality of care, including but not limited to prompt notification of abnormal test results	X	X	X
Be aware of True Health New Mexico's in-network participating providers, labs, Durable Medical Equipment (DME) providers, and other service providers in order to minimize delays, inconvenience, and billing problems for True Health New Mexico members.	X	X	X
Maintain current medical records in accordance with state and federal regulatory requirements, and document communication with other providers in the member's medical record.	X	X	X
Collect specified copayments and verify member eligibility and benefit certification for covered services.	X	X	X
Confirm benefit eligibility from True Health New Mexico for non-emergent inpatient and outpatient services in accordance with the member's benefit package.	X	X	X
Agree to treat all patients equally, without discriminating on the basis of gender, age, ethnicity, sexual orientation, disability, race, religion, place of residence, health status, member status, income level, without regard to source of payment made for services rendered, or on any basis prohibited by federal or state law.	X	X	X
Respect the cultural and religious concerns of patients. Determine if members have any special cultural needs (e.g., concerns regarding blood or blood products, transplants, end-of-life care) special language needs, etc.	X	X	X
Report abuse or neglect of a child or vulnerable adult (revealed to a provider or suspected by a provider) to proper regulatory authorities pursuant to state law and contacting Children, Youth, and Families at (505) 841-6100 or Statewide Central Reporting Intake at 1-800-797- 3260.	X	X	X
Provide routine office visits (including evaluation, diagnosis, and treatment of illness and injury) and preventive health services in accordance with practice guidelines and medical policies.	X		

Responsibility	PCP	Specialist	MH/BH
Communicate with the other in-network referring providers regarding services rendered, results, reports and recommendations to ensure continuity and quality of care.	X	X	X
Guide members in self-management, goal setting and planning.	X		
Guide members on how to use available health care services and treatment.	X	X	X
Provide or arrange for the provision of services to designated laboratory, radiology, and pharmacy facilities.	X	X	X
Provide health education services for members and their families.	X	X	X
Prescribe generic pharmaceuticals, where medically appropriate, and within True Health New Mexico's formulary and formulary exceptions process.	X	X	X
Administer injections, including adult and pediatric immunizations, in accordance with medical practice standards.	X		
Provide or arrange for the provision of medically related social services including behavioral health or chemical dependency.	X	X	X
Inform patients of their right to know about all treatment options related to their conditions or disease processes, whether or not recommended services are covered benefits.	X	X	X
Maintain admitting privileges at a participating hospital within the service area or have a mechanism for admitting panel members.	X	X	X
Provide or arrange for the provision of covered services and telephone consultations during normal office hours and on an emergency basis, 24 hours a day, seven days a week.	X		
When the PCP is unavailable, coverage should be arranged through a participating True Health New Mexico health care professional or with an on-call health care professional who has signed a coverage arrangement with a participating PCP.	X		



MEDICAL MANAGEMENT

Utilization Management Process

The True Health New Mexico Medical Management Team evaluates requests for coverage in order to ensure that services rendered to members are medically necessary and/or appropriate, occur in the appropriate setting, and are included in the member's benefit coverage. True Health New Mexico utilizes nationally recognized criteria (including InterQual®), evidence-based guidelines, and True Health New Mexico medical policies for clinical decision making. Utilization Management encompasses services rendered in ambulatory, inpatient, and transitional settings.

Upon request, True Health New Mexico will provide a copy of the clinical rationale and medical criteria used to make the determination; there is no charge for this request. To obtain a copy, please contact the True Health New Mexico Medical Management Team at 1-844-508-4677, option 3, Monday through Friday, between 8:00 and 5:00 p.m., Mountain Time, or send a written request to:

True Health New Mexico
ATTN: Medical Management
P.O. Box 200788
Austin, TX 78720

Utilization management for the True Health New Mexico pharmacy benefit is managed by True Health New Mexico Pharmacy Services. Please see the [Pharmacy Section](#) of the handbook for details.

Concurrent Review

Concurrent review is an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. True Health New Mexico will determine if a concurrent approval is necessary and will notify the member and provider by phone and in writing.

Post-Service Review

Post-service review is any review for care or services that have already been received, e.g., retrospective review. Post-service determinations include any requests for coverage of care or service that a member has already received. Determinations will be made within thirty (30) calendar days of receipt of the request.

Expedited Review

The expedited review will be conducted when True Health New Mexico determines, or when a provider indicates a delay would seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum functions.

Adverse Determinations



While all requests for services that require prior or concurrent authorization will be reviewed by an appropriate clinical professional, all adverse determinations will be referred to a True Health New Mexico

Medical Director for an adverse determination decision. Prior to a formal appeal, providers may discuss the decision with the applicable True Health New Mexico Medical Director who made the adverse determination, which includes a peer-to-peer conversation around the clinical evidence involved in the case.



CASE MANAGEMENT

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet complex health needs of True Health New Mexico members. Case Management is an integral part of True Health New Mexico's Medical Management program because it allows True Health New Mexico to partner with providers to prevent fragmented, episodic care for our members. Research and experience show that a higher-touch, member-centric care environment for at-risk members supports better health outcomes.

Keys to Case Management are:

- Coordination
- Monitoring of Service Delivery
- Advocacy
- Evaluation
- Reassessment

True Health New Mexico is committed to the delivery of high-quality case management programs to its members. True Health New Mexico places its members either into Level 1 Case Management or Complex Case Management. The level of case management is determined by an assessment of the member's needs using an evidenced-based assessment tool, which develops a coordinated, member-focused, and multi-disciplinary plan of care. The plan of care is designed to meet the specific health needs of the member with the ultimate goal of helping members regain optimum health or improved functional capability in the right setting and in a cost-effective manner.

The True Health New Mexico Case Management program is available to all True Health New Mexico members. While True Health New Mexico monitors claims, utilization patterns, and other health plan data, True Health accepts referrals into any level of case management from members, caregivers, discharge planners, nurse advice line teams, and providers.

Levels of Case Management

- Level 1 Case Management
- Complex Case Management

Level 1 Case Management Criteria (includes both medical and behavioral health Case Management)

- Recent, self-limiting, acute injury, or illness
- Exacerbation of a chronic condition, and may be at risk for complications or readmission
- Inappropriate utilization of services such as repeated emergency department visits
- Medication non-adherence

Complex Case Management Criteria

- Major organ transplant
- Catastrophic illness
- Multiple medical problems
- Non-compliance or resistance to treatment

Complex Case Management Criteria *(continued)*

- Inability to follow treatment plan
- Repeated or unexpected readmissions
- Members with multiple providers
- Complex medical condition such as acute brain injury or respiratory failure
- Complex psychosocial needs that are interfering with member's ability to obtain appropriate medical care

Case Management Value to Providers

The Case Manager:

- Obtains information about the home environment regarding barriers to recovery.
- Evaluates family dynamics and the family's impact on the patient's response to the treatment you have prescribed.
- Assesses the member's/family's degree of motivation toward achieving optimal function.
- Provides education on the member's disease process.
- Monitors progress towards treatment goals and the need for additional education and/or clarification of information.
- Explains and maximizes the member's available health plan benefits.
- Provides coordination of health care services.
- Connects members with community resources.

Providers receive the following when their patients/ True Health New Mexico members enroll in Case Management:

- Written or telephonic notification when a member who is the provider's patient is enrolled in a Case Management program.
- A copy of the individualized care plan created for the member is available upon request.
- Communication from the Case Manager on the member's progress toward goals.

Referral to Case Management

To refer a member:

- By phone: Please contact Case Management at 1-844-691-9984.
- By fax: Complete the Complex Case Management Practitioner/Provider Referral Form on truehealthnewmexico.com/provider-forms-and-other-resources/ and fax to 1-866-628-3047.

How to Contact Us



- Phone: 1-844-691-9984
- Fax: 1-866-628-3047

Transition of Care

If a member is receiving an ongoing course of treatment from a Non-Participating Provider when he/she enrolls in the Plan, or with a Participating Provider whose contract ends during a course of treatment, the member may be eligible to continue to receive services and have them covered by the Plan. This is called a Transition of Care. Determinations for Transition of Care are made based on established medical criteria.

The Transition of Care Period will be for a period of no less than thirty (30) days. Transition of Care also applies to members who have entered the third trimester of pregnancy, including post-partum care directly related to the delivery.

Disease Management

True Health New Mexico is committed to supporting providers in the management of chronic conditions. True Health New Mexico Disease Management programs play an integral role in improving the quality of life and promoting cost effective outcomes for True Health New Mexico members with asthma and diabetes. Following are brief descriptions of the True Health New Mexico Asthma and Diabetes Disease Management programs:

Asthma is a chronic disease that can be controlled with client education, medication management, and identification and elimination of asthma triggers in the environment. True Health New Mexico's Asthma Management Program is designed to identify and improve clinical outcomes for our members with asthma, through the development and promotion of strategies that lead to better quality health care, cost effective outcomes, and higher member satisfaction. The program incorporates a structured process that defines goals, interventions, and outcome measures and provides guidance and focus for improvement. Interventions are based on best practices designed to address the obstacles and unique complexities that this vulnerable population faces and is consistent with the Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, dated 2007, of the National Heart, Lung, and Blood Institute, adopted by True Health New Mexico in 2018.

The overall program goal is to control asthma by reducing impairment and risk, resulting in improved clinical outcomes and decreased health care costs.

This **goal** is accomplished through:

- Proactively identifying members with asthma.
- Analyzing and stratifying risks factors to determine which level of intervention member will receive.
- Outreaching, educating, and engaging asthmatic members and their families in interventions to improve their health care outcomes and to develop asthma self-management strategies.

- Facilitating communication, teamwork, coordination and management of necessary health care services.
- Assisting members requiring community resources such as transportation and food stamps.

Outcomes measures used to assess the effectiveness of the program include:

- Reduction in asthma-related emergency room utilization.
- Reduction in asthma-related inpatient hospital admissions.
- Improvement in appropriate medication treatment for members with asthma.
- Member program satisfaction and self-reported improvement in asthma management.

Diabetes is a chronic disease that can be controlled with client education, medication management, and identification and elimination of triggers in the environment. True Health New Mexico's Diabetes Management Program is designed to identify and improve clinical outcomes for our members with diabetes, through the development and promotion of strategies that lead to better quality health care, cost effective outcomes, and higher member satisfaction. The program incorporates a structured process that defines goals, interventions, and outcome measures and provides guidance and focus for improvement. Interventions are based on best practices designed to address the obstacles and unique complexities that this population faces, and are consistent with the American Diabetes Association, Diabetes Care, Standards of Medical Care in Diabetes, 2012 adopted by True Health New Mexico in 2018.

The overall program goal is to control diabetes by reducing impairment and risk, resulting in improved clinical outcomes and decreased health care costs.

This **goal** is accomplished through:

- Proactively identifying members with diabetes.
- Analyzing and stratifying risks factors to determine which level of intervention member will receive.
- Outreaching, educating, and engaging diabetic members and their families in interventions to improve their health care outcomes and to develop diabetes self-management strategies.
- Facilitating communication, teamwork, coordination and management of necessary health care services.
- Assisting members requiring community resources such as transportation and food stamps.

Outcomes measures used to assess the effectiveness of the program include:

- Reduction in diabetes-related emergency room utilization.
- Reduction in diabetes-related inpatient hospital admissions.
- Improvement in appropriate screenings such as low-density lipoprotein, hemoglobin A1c, and microalbuminuria (dependent on available client data).
- Member program satisfaction and self-reported improvement in diabetes management.



Referrals to the disease management program can be initiated by contacting the True Health New Mexico Medical Management department at 1-844-691-9984. For more information about True Health New Mexico Disease Management program, please call 1-844-691-9984.

True Health New Mexico Care Connect Line

True Health New Mexico has a nurse advice line available exclusively to True Health New Mexico members 24 hours per day, 7 days per week, 365 days per year. Experienced registered nurses answer questions and provide confidential medical advice, at no cost. Nurses also refer callers to True Health New Mexico Case Management and Disease Management programs when appropriate.

Members can call the True Health New Mexico Care Connect Line at 1-844-308-2552.

Attestation Regarding Decision-Making and Compensation

True Health New Mexico does not provide incentives for Care Management staff based on any utilization review decisions. All review decisions are based upon appropriate care and benefit coverage.

Utilization Management Affirmation Statement

Utilization management decision making is based only on appropriateness of care and service, and existence of coverage. There are no rewards to practitioners or other individuals for issuing denials of coverage or requested services. There are no financial incentives for any utilization management decision makers that encourage decisions that result in underutilization.

Initial or continued requests for treatment or length of stay may be approved by the designated Care Management Staff, based on the clinical information provided and reviewed against explicit criteria. All utilization adverse determinations/ denial decisions are made by Medical Directors.



PHARMACY

True Health New Mexico offers formularies (preferred drug lists) for all benefit plans. Formularies are managed and maintained by True Health New Mexico Pharmacy Services. The True Health New Mexico pharmacy benefit is provided and managed by CVS/Caremark™, a national pharmacy network with over 60,000 pharmacies across the country.

Pharmacy & Therapeutics Committee

The True Health New Mexico formulary and the policies and procedures regarding managing the formulary are reviewed and approved by the Evolent Pharmacy & Therapeutics (P&T) Committee, which is comprised of actively practicing physicians, actively practicing pharmacists and other licensed health care professionals. P&T Committee members exercise their professional judgment in making determinations based on clinical and scientific evidence and analyses. The P&T Committee reviews the formulary and policies annually, and updates occur as information from the Food and Drug Administration (FDA), Centers for Medicare & Medicaid Services (CMS), or when sound clinical evidence becomes available.

In its evaluation, review, guidance and clinical recommendations, the P&T Committee shall:

- Make recommendations on the therapeutic placement and appropriate prescribing guidelines for prescription drug products, and as appropriate, medical device products, intended for use in an ambulatory care setting.
- Provide ongoing review and monitoring of the safety, effectiveness, and quality of care of products contained within the formulary and in True Health New Mexico's clinical programs.
- Initiate and/or review recommended Drug Utilization Review and Drug Use Evaluation programs.
- As necessary, review, advise, and approve utilization management guidelines, including prior authorization, step therapies and quantity limits.
- Advise True Health New Mexico on suitable educational programs (e.g., for health care provider networks, Plan Participants, and pharmacy providers).
- Make recommendations for the implementation of effective product utilization control procedures.

In addition to making clinical recommendations to the formulary, the P&T Committee shall provide information to medical, health care, and related pharmacy benefit professionals on matters pertaining to the clinical management of prescription drug and medical device usage by:

- Establishing policies and procedures to educate and inform health care professionals about
- products, product usage, and the P&T Committee's clinical recommendations;
- Overseeing quality improvement programs that employ product use evaluation;
- Providing recommendations for implementation of generic substitution and therapeutic interchange programs based upon clinical and medical analysis and assessment; and



- Evaluating, analyzing and reviewing protocols for the use of and access to non-formulary products.

Additional responsibilities may be established and delegated to the P&T Committee, as determined by the Chief Medical Officer.

True Health New Mexico Formulary

True Health New Mexico maintains the formulary for outpatient medications, which may be prescribed by any True Health New Mexico provider. True Health New Mexico providers are required to use formulary medications whenever medically appropriate. Specialty medications must be received from CVS Specialty. Pharmacists will not fill prescriptions for True Health New Mexico members for non-formulary drugs unless an approval has been received from True Health New Mexico Pharmacy Services. Limits and quotas on drugs are set as needed by the P&T committee based on best medical evidence and communicated to providers through regular provider updates such as newsletters or other communications.



True Health New Mexico's formulary AND formulary/utilization management updates are available at truehealthnewmexico.com/member-pharmacy-formulary/.

Formulary and utilization management updates are posted monthly, or as needed. If you need assistance with the formulary or in obtaining authorization, call True Health New Mexico Pharmacy Services at 1-866-823-1606. Formulary exceptions are processed by True Health New Mexico Pharmacy Services based on medical necessity.

Covered medications include:

- **Group plans** allow up to a **90-day supply** of drugs requiring a prescription under state or federal law.
- **Group plans** allow up to a **90-day supply** of drugs when purchasing through the mail-order program or through retail pharmacies.
- Specialty medications with prior approval.

The prescription drug member cost-shares for True Health New Mexico members are listed on the member ID card. For members whose benefits allow up-to a 90-day supply of medications, True Health offers a mail order prescription service for on-going maintenance medications.

Exclusions include but are not limited to:

- Non-prescription drugs (unless listed on the formulary)
- Medications excluded by regulation as described by the Centers for Medicare & Medicaid Services (CMS)
- Personal care items

- Cosmetic drugs (drugs that are applied to the body for purposes of cleansing, beautifying, promoting attractiveness, or altering the appearance)
- Appetite suppressants/weight-loss drugs, dietary supplements, prescription vitamins (other than prenatal), fluoride products
- Experimental drugs (drugs or combinations of drugs that have not been approved by the FDA)
- Erectile dysfunction drugs

Formulary Exceptions, Prior Authorizations, and Appeals

All requests which require approval for formulary exceptions should utilize the Drug Prior Authorization Request Form and should be faxed to True Health New Mexico Pharmacy Services.



Requests for Pharmacy Prior Authorizations can be faxed to True Health New Mexico Pharmacy Services at 866-718-7938 OR may be called into Pharmacy Services at 866-823-1606.

Medications that Require Prior Authorization

Medications that require prior authorization include, but are not limited to:

- Biologics
- Genomic drugs
- Monoclonal antibody and TNF inhibitors

Visit the True Health New Mexico website for more information:

truehealthnewmexico.com/member-pharmacy-formulary/.

ADDITIONAL INFORMATION

Any questions can be directed to True Health New Mexico Pharmacy Services at 1-866-823-1606. In all cases, the review and approval/denial of formulary exceptions will be executed as expeditiously as possible (but generally will not take longer than 72 hours). A provider requesting an exception should provide the following information:

- Patient's name
- Patient's date of birth
- Patient's member ID
- Medication requested
- Name of pharmacy the patient accesses to fill prescriptions
- Medical indication for request
- Alternative medicines tried in the past
- Clinical notes/labs/imaging to support diagnosis and prior medication trials.
- Provider contact information

Prospective review procedures and guidelines for formulary exceptions are developed and updated by and in conjunction with the Evolent P&T Committee and other specialist providers who have agreed to work with True Health New Mexico to provide expert guidance. In the event that a request for a coverage determination cannot be approved with the available clinical information, the prescriber, and the member are notified telephonically and in writing of the coverage determination.

The written notification to the provider and the member will contain the rationale for the determination and a description of the appeal process. Additionally, the drug use by True Health New Mexico members is reviewed to determine if use is appropriate, safe, and meets current medication therapy standards.

Providers may request copies of the criteria/guideline used to make decisions about formulary exceptions by calling True Health New Mexico Pharmacy Services at 1-866-823-1606.

The prescribed drug will be considered for coverage under the pharmacy benefit program when the following criteria are met:

- A formulary alternative is not appropriate for this patient (e.g., patient has a contraindication or intolerance to the formulary alternative, etc.); and
- The medication is being prescribed for an FDA approved indication OR the patient has a diagnosis that is considered medically acceptable in the approved compendia* or a peer-reviewed medical journal; and The patient does not have any contraindications or significant safety concerns with using the prescribed drug.

An approval will be granted for patients who meet the above criteria. If the patient does not meet the above criteria, the prescribed use is considered experimental/investigational for conditions not listed in this coverage policy section.



Generic Substitution

Generic medications contain the same active ingredients as brand name medications, but often cost less. The True Health New Mexico formulary covers many generic medications, including a significant number of drugs that are available to the member with \$0 cost share. When available, generics provide a valuable option and may reduce member cost share. When a new generic becomes available, the formulary is updated, and the brand-name medication will be removed from the formulary. If a generic drug does not meet the clinical needs of the patient, providers can request a pharmacy exception/prior authorization for the branded product.

Therapeutic Interchange

A therapeutic interchange will only be made if a provider has received and approved a recommendation for a medication change. True Health New Mexico does not automatically perform therapeutic interchanges.

Step Therapy

True Health New Mexico updates Utilization Management programs, including Step Therapy, on a regular basis. True Health New Mexico will notify members who may be negatively affected by these changes. In circumstances where use of a drug impacted by step therapy has been previously established, True Health New Mexico will provide members impacted by the step therapy program with a temporary supply of medication, pending the outcome of the exception request.

Site-of-Care Program

True Health New Mexico partners with Optum Infusion Services on a site-of-care program. This program seeks to direct members from a higher-cost, less convenient site of care to a lower-cost, more convenient site of care. This program targets a limited number of infused medications used to treat chronic conditions. Optum Infusion Services has an ambulatory infusion suite in Albuquerque and can also offer at-home infusion options for True Health New Mexico members throughout New Mexico.

Online Tools

True Health New Mexico members and providers are encouraged to use online tools available at caremark.com. Some actions a member or provider may perform online include:

- Determine copay or coinsurance amount for a medication
- Initiate the exception process
- Order a refill for an existing, unexpired mail order prescription
- Locate in-network pharmacies
- Determine potential drug interactions or side effects
- Look for generic substitutes



- The e-prescribing component of many electronic medical records (EMR) systems may allow providers to view information about drug cost/coverage alternatives and may allow submission of prior authorization requests within the EMR.

Provider Resources

The pharmacy page of the True Health New Mexico website includes resources for prescribes, including:

- List of Formulary Alternatives
- List of zero-dollar cost share generics
- Formulary and/or Utilization Management updates
- Drug Safety Updates
- Safe Opioid Use Tools/Forms

The True Health New Mexico formulary is available at truehealthnewmexico.com/member-pharmacy-formulary/.

***The approved compendia include:**

- American Hospital Formulary Service (AHFS) Compendium
- IBM Micromedex Compendium
- Elsevier Gold Standard's Clinical Pharmacology Compendium
- National Comprehensive Cancer Network Drugs and Biologics Compendium



AUTHORIZATIONS

Authorization is a request for services, a procedure, or an admission to a hospital or facility that must be obtained before any such service is given or within 24-hours after an emergency. A prior authorization is required for services, procedures, or admissions that require medical necessity review. Prior authorization is not a guarantee of payment.

Non-contracted providers are required to obtain prior authorization except for services provided in an emergency department. Claims will be reviewed to determine member eligibility at the time of service, benefit availability, evidence of coverage provisions, and claims payment agreements. Benefits are determined by each Member's plan. Failure to obtain necessary prior authorization or provide notification within the stipulated time frame will result in denial of the service and associated costs.

Obtaining Authorization for Pre- and Concurrent Review Services

For all services that require an authorization, the provider must contact the True Health New Mexico Medical Management department at 1-844-508-4677, option 3.

Authorization requests may be phoned in to True Health New Mexico Medical Management during normal business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m. MST, or faxed to 1-866-628-3047. If providers require assistance for urgent (expedited) determinations after business hours, please call 1-844-508-4677 to reach an on-call nurse case manager.

Requests for authorizations must be made before the anticipated procedure, transfer, admission, or service is provided.

Please include the following information in a Request for Authorization or for Concurrent Review for continued coverage of care:

- Member's name and subscriber number
- Scheduled date of procedure, transfer, admission, or service
- Name of attending, referring, or ordering physician
- Location of service and rendering physician
- Diagnosis
- Procedure
- Supporting clinical/medical information for request

For detailed information regarding determinations, please contact the team at 1-844-508-4677.



Prior Authorization

Prior authorization is the process of reviewing a requested medical service or item to determine if it is medically necessary and covered under the member’s plan. Prior authorization is part of the utilization management process and case management model. Determinations for medical appropriateness are made by evaluating information from the requesting physician, the member’s medical records, consultations, and relevant laboratory and radiological information.

True Health New Mexico will determine if services where a prior authorization is required and will notify the member and the provider of the determination by phone and in writing.

Among other services, True Health New Mexico requires prior authorization for all elective hospitalizations, transfers to non-participating facilities, skilled nursing facility admissions, acute rehabilitation facility admissions, and advanced radiology services (CT, MRI, and PET scans). Prior authorization is also required for certain ambulatory services and DME.

Authorization Response Times and Contacts			
Authorization Type	Commercial/ASO	Federal Employee Health Benefit	True Health New Mexico Contact
Concurrent Review <i>(Member is In-Patient)</i>	24 hours	24 hours	Contact Utilization Management by PHONE: 844-508-4677
Expedited Medical Pre-Service	24 hours	72 hours	Contact Utilization Management by PHONE: 844-508-4677
Routine Medical Pre-Service	5 business days	15 calendar days	Complete the Prior Authorization Form and fax to UM at FAX: 866-446-3774
Expedited Pharmacy	24 hours	72 hours	Contact Pharmacy Services by PHONE: 866-823-1606
Routine Pharmacy	3 business days	15 calendar days	Complete the Prior Authorization Form and fax to Pharmacy Services at FAX: 866-718-7938



For a complete list of services that require prior authorization, please visit truehealthnewmexico.com/prior-authorization-requests/.

Prior Authorization Resources	
Online Prior Authorization Reference Guide	truehealthnewmexico.com/providers/ (Provider Handbook)
Electronic Prior Authorization Submission	truehealthnewmexico.com/prior-authorization-requests/
Download True Health New Mexico Prior Authorization Form	truehealthnewmexico.com/prior-authorization-requests/
Fax True Health New Mexico Prior Authorization Form	Fax: 1-866-446-3774
Telephone Contact for Prior Authorization	1-844-508-4677

Please visit truehealthnewmexico.com/prior-authorization-requests/ and download the True Health New Mexico Prior Authorization Request form. True Health New Mexico uses the state-mandated prior authorization request form.

New Technology

Newly published/assigned codes and new/emerging therapy services or technology not listed may require prior authorization to determine medical necessity. Check with True Health New Mexico before providing these types of services. The authorization requirements are updated at least bi-annually and may change at any time.

Please refer to the [Pharmacy](#) section of the handbook for more information on medications that require prior authorization or refer to the True Health New Mexico website.

NOTE: Due to circumstances regarding member eligibility and timeliness standards, an authorization is not a guarantee of payment. Prior authorization also does not guarantee payment in cases of fraud and/or misrepresentation. Such cases may include the addition of procedures that were not originally authorized and/or information not originally provided.

You can find the Medical Prior Authorization List at truehealthnewmexico.com/prior-authorization-requests/.

Prior Notification

True Health New Mexico also requires notification for certain services so that assistance with discharge planning, care coordination, and case management can be provided. All services must



be medically necessary, appropriate and meet True Health New Mexico coverage criteria where applicable.

For a complete list of services that require prior notification, please visit truehealthnewmexico.com/prior-authorization-requests/.

REIMBURSEMENT POLICY

Reimbursement and Fee Schedules

These policies apply to all True Health New Mexico plans, including Federal Health Employee Benefit plans. The member's contracted health plan benefits must be in effect on the date that services are rendered. True Health New Mexico reserves the right to review and update its Reimbursement Policies, so it is important to review this information regularly.

True Health New Mexico typically reimburses its providers based on the current CMS Medicare fee schedule. However, other reimbursement based on True Health New Mexico or provider need may be negotiated and approved. True Health New Mexico may adopt reimbursement or methodology changes required by CMS guidance or federal or state laws/regulations and may incorporate **annual** CMS increases or decreases to the fee schedules. Although the CMS fee schedule is the primary source, True Health New Mexico occasionally may process claims outside of the standardized CMS payment logic.

Although not a complete list, the primary fee schedules are:

- CMS Inpatient Prospective Services (IPPS)
- CMS Outpatient Prospective Services (OPPS)
- Physician Fee Schedule (MPFS)
- Durable medical equipment, prosthetics and orthotics, and supplies (DMEPOS)
- CMS Clinical Laboratory Fee Schedule
- CMS Average Sales Price (ASP)
- Home Health PPS
- Hospice PPS
- Other applicable CMS fee schedules
- Ambulatory Surgical Center (ASC) payment fee schedule

In all cases, it is True Health New Mexico's policy to reimburse providers the lesser of the provider's billed charge or the provider's contracted reimbursement rate.

To calculate reimbursement, go to the [easy-to-use CMS lookup tool](#):

[CMS.GOV/MEDICARE/MEDICARE-FEE-FOR-SERVICE-PAYMENT/PFSLOOKUP/INDEX.HTML](https://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html). Enter a CPT or HCPCS code to calculate 100 percent of reimbursement. Be sure to apply your contracted allowable percentage, and locality code, if applicable.

Reimbursement of Covered Non-Contracted Goods and Services

It is True Health New Mexico's policy to reimburse, rather than to deny, payment to contracted network providers when the provider submits claims for goods or services without a negotiated reimbursement rate for those specific goods and services included within the provider's contract with True Health New Mexico.



Reimbursement is contingent on the goods or services being a covered benefit, and contingent on the provider following True Health New Mexico guidelines for obtaining health plan authorization for the good or service or providing the appropriate notification to the health plan prior to the service rendered. Providers must also treat members within their scope of practice specialty.

The following are examples of covered non-contracted goods or services:

- Durable Medical Equipment (DME) (goods) dispensed to a member without a negotiated DME reimbursement rate within the dispensing provider's contract with True Health New Mexico.
- Infusion drugs (goods and/or services) administered to a member without a negotiated reimbursement rate for drugs or "J" codes within the dispensing provider's contract with True Health New Mexico.
- Lab tests drawn and/or tested by provider or provider's lab with no negotiated lab reimbursement rate within the provider's contract with True Health New Mexico.

While True Health New Mexico is not a CMS entity, True Health New Mexico will utilize the lesser of the provider's billed charge, or CMS's reimbursement methodology and fee schedules, to administer usual and customary payment for covered non-contracted goods and services.

The following are examples of, but not limited to, the fee schedules True Health New Mexico uses to administer payment of covered non-contracted goods and services:

- CMS DMEPOS: Durable Medical Equipment and Prosthetics and Orthotics
- CMS ASP: Drugs, Infusion, Injectables
- CMS CLFS: Clinical Laboratory Fee Schedule

Facility "Overhead" Reimbursement Policy

A Facility Overhead Charge is a clinic charge for any technical component or overhead that is billed by a facility when a professional provider renders covered services to True Health New Mexico members in a facility clinic setting.

True Health New Mexico defines a facility clinic visit as a preventive, curative, diagnostic, rehabilitative, and/or education service provided to an ambulatory patient in an outpatient setting; whether in a freestanding or attached facility that is owned, operated, leased, or controlled by the facility.

Unless otherwise agreed upon in writing, True Health New Mexico reimburses professional providers for covered services provided in a facility clinic setting when filed on a CMS-1500 form with place of service codes to include, but not limited to, place of service 11, 20, or 22 (Office, Urgent Care, Outpatient). This reimbursement will always include both the professional services and the associated overhead.

Some examples of a facility clinic visit include, but are not limited to a member:



- Having blood drawn for lab work at a facility draw station
- Seeing a behavioral health provider on a hospital campus
- Getting an X-ray at a diagnostic center
- Seeing his or her PCP at an off-campus hospital owned facility
- Receiving education from a nutritionist on a hospital campus

Provider-Based/Split Billing

Provider-based billing refers to the Medicare allowed practice of splitting bills for clinic and/or physician practices owned, controlled by or affiliated with a hospital. Under split billing, the hospital submits a bill for the technical component of the service on a UB-04 Hospital Claim form while the physician services are billed separately on a CMS-1500 Professional Claim form. Unless otherwise agreed upon in writing, True Health New Mexico will not reimburse for facility services billed on a UB-04. While True Health New Mexico may utilize Medicare fee schedules and CMS methodology to adjudicate claims, True Health New Mexico is not a Medicare entity, and does not recognize or reimburse facility overhead charges, provider-based or split billing.

True Health New Mexico **will not** separately reimburse a facility for facility clinic visits and services billed on a UB-04, or any other form, when reported with revenue codes 0510-0525 and 0527-0529 and any successor codes, including but not limited to the accompanying G Codes.

True Health New Mexico **will not** separately reimburse for specialty services/treatment room revenue codes 0760-0769 when billed on a UB-04, or any other form.

This policy applies regardless of whether or not the clinic uses the hospital tax identification number for claims and includes any services performed in an outpatient setting or clinic; regardless of if the clinic is an on-campus or off-campus outpatient hospital setting.

The reimbursement for technical and overhead components of the facility clinic visit are included in the reimbursement paid to the professional provider for professional services, as reported on the CMS-1500 form. This includes, but is not limited to, place of service codes 11, 20, and 22. These services may encompass but are not limited to Evaluation and Management health care services provided to True Health New Mexico members in a clinic setting.

The facility may not seek reimbursement for any technical or overhead component of the clinic charge from True Health New Mexico or from its members. The member is held harmless and may not be balance-billed by the provider for clinic facility charges.

In accordance with the terms of the Agreement with True Health New Mexico, True Health New Mexico reserves the right to recover overpayments resulting from separately billed clinic/facility fees billed in combination with a professional office/clinic visit claim.

Provider based billing claim refers to a claim submitted with at least one service including, but not limited to: Surgery, lab, radiology, drugs and supplies billed with revenue codes 0510-0529



or with revenue codes 0760-0761 and E&M Office Visit CPT/HCPCS codes, including but not limited to, 99200-99205; 99211-99215; 99241-99245; 99354,99355, 99381-99387, 99391-99391, 99401-99412, 99429, 99450, 99455-99456, 99487-99489, 99499.

Some examples of a facility clinic visit billed on a UB-04 which include non-covered revenue codes include, but are not limited to, situations when a member:

- Receives procedures such as dialysis or emergency department procedures in a clinic.
- Listed revenue codes billed in conjunction with PICC line insertion.
- Listed revenue codes billed in conjunction with a Procedure (CPT) in addition to Cast Room, the Cast Room is not separately reimbursable.
- Listed revenue codes billed in conjunction with insertion of a peripheral IV, the treatment room is not separately reimbursable.

Telehealth Services

Telehealth Services refer to the provision of healthcare through electronic telecommunications technology. In this handbook, Telehealth refers specifically to the delivery of healthcare through a two-way, real-time, interactive communication between a Member and a Provider at a distant site, through a HIPAA compliant platform that includes, at minimum, audio and visual equipment.

Telehealth services are a covered benefit for True Health New Mexico Members when rendered by Medical and Behavioral Health Providers. True Health New Mexico does not limit the provision of telehealth services to only rural areas and follows CMS guidelines regarding services deemed appropriate for provision in a telehealth setting. The list of Telehealth approved codes can be found at www.cms.gov. If medically necessary, True Health New Mexico will reimburse Telehealth encounters on par with in-person office visits. These services are typically for the purpose of evaluations, follow-up care, or treatment of a specific condition.

Common Telehealth Terminology

- **Distance Site:** The remote site; site where the Qualified Health Professional is performing the service.
- **Originating Site:** The hosting site; a health care facility at which the patient is located at the time services are provided by means of telemedicine.

Requirements

- The Member must be present at the time of service.
- Services must be medically necessary and otherwise covered under the Member's Benefit Plan.
- Services must be within the provider's scope of license.
- The totality of the communication of information exchanged between the Physician or other Qualified Healthcare Professional and the Member during the course of the Telehealth service must be of an amount and nature that would be sufficient to meet



the key components and/or requirements of the service when rendered via face-to-face interaction.

- The telehealth fee is paid to the Originating Site and should be submitted using HCPCS Q3014.

Professional Claim Submission for Covered Services Billed on a HCFA 1500:

- Claim must be submitted using Place of Service (POS) 02.
 - Use of POS 02 indicates that the distant clinician services were provided via a secure platform and rendered in real-time via interactive video and/or audio telecommunications.
- Inclusion of modifiers GT, GQ, and G0 are not required, but are accepted if included.

Facility Claim Submission for Covered Services Billed on a UB-04:

- Require use of modifier 95
 - Use of modifier 95 indicates that the service was rendered via secure, synchronous, real-time interactive audio and/or video with a member who is located at a distant site.



CLAIMS SUBMISSION AND PAYMENT

True Health New Mexico has implemented claims program requirements to ensure timely and accurate processing of claims for participating providers.

Members are also required to follow the applicable requirements of their plan to receive benefits.

Member Eligibility and Benefits

Providers must verify that a patient is an eligible member of the Plan and should verify benefits prior to rendering services.

True Health New Mexico encourages providers to verify a member's eligibility status throughout the period of continued and/or extended services as eligibility may change at any time. It is not uncommon for retroactive terminations to occur, which may affect the status of a member's eligibility. For this reason, verification of eligibility is not a guarantee of payment.

Provider offices should consider the following as a guide to help obtain verification of eligibility and benefits:

- All True Health New Mexico members must present their ID card at the time of service. Providers should further verify eligibility and benefits. Providers can use the link to the Provider Portal from our website at truehealthnewmexico.com/providers/.
- Providers should review the Prior Authorization Requirements prior to rendering services to determine whether-or-not prior authorization is required.
- Collect the member's cost-share requirement at the time of service.

Billing Members for Services

Providers may not bill members for any covered services, except for applicable copays, deductibles, and/or coinsurance amounts. Members may not be billed for services due to a provider's failure to obtain required authorizations. Any deductibles and/or coinsurance and charges for non-covered services must be billed to the member following the receipt of the Explanation of Payment (EOP) from True Health New Mexico.

Providers may not require payment from a member for any non-covered service that the member receives, unless the member is informed that the services are non-covered and has agreed in writing, in advance of receiving the services, to pay for such services. A member informed by the provider that care is potentially non-covered, and proceeds with receiving the potentially non-covered service, may not be billed for the non-covered service by the provider, unless the member has previously agreed in writing to pay for the service.

Any waivers signed by the member must be specific as to the details of the excluded or non-covered service and its cost. General agreements to pay, such as those signed by the member



at the time of service, are not evidence that the member knew specific services were excluded or excludable or that the member agreed to pay.

Claims Submission

Providers are required to submit clean claims for any services rendered to True Health New Mexico members. True Health New Mexico is required to process clean claims within thirty (30) days of receipt for electronic submissions, and forty-five (45) days for paper submissions. Providers will receive an Explanation of Payment (EOP) for all claims received.

A clean claim is a manually or electronically submitted claim that:

- Contains substantially all the required data elements necessary for accurate adjudication in accordance with the terms and conditions of the applicable plan and without the need for additional information;
- Is not materially deficient or improper, including lacking substantiating documentation currently required by the payor;
- Presents no mitigating or unusual circumstances (including the need for current coordination of benefits information) that prevent payment from being made in accordance with required time-frames; and
- Is submitted within True Health New Mexico's timely filing requirements.

Accurate and timely submission of claims for billing is a critical component to timely and accurate provider compensation.

Additional tips for submitting claims are:

- Submit clean claims on a CMS-1500 form or UB04 form that is compliant with the National Provider Identifier (NPI) and Health Insurance Portability and Accountability Act (HIPAA) regulations. Valid CPT, Revenue, HCPCS, ASA, and ICD-10 codes must be used and include appropriate modifiers, if applicable.
- True Health New Mexico may require additional information for particular types of services or based on particular circumstances or state requirements.
- While some claims may require supporting information for initial review, True Health New Mexico will request additional information when needed.

For questions about claims, filing, or contracted reimbursement, please contact True Health New Mexico's Customer Care center at 1-844-508-4677.

Effective December 1, 2022, **Availity** is True Health New Mexico's electronic data interchange (EDI) vendor for electronic claim submission.

Time Frame for Filing Claims

- Claims must be submitted no later than thirty (30) days after the provision of covered services. No payment shall be made for claims submitted more than 90-days after the provision of covered services, unless otherwise approved in writing.



- In cases in which True Health New Mexico is the secondary payor, claims must be filed ninety (90) days from the date of service or ninety (90) days from the date that the Provider receives notice of payment decision from the primary payor, whichever is later.

Only those charges for Covered Services billed in accordance with True Health New Mexico’s standard claim coding and bundling methodology will be considered for payment. The Plan reserves the right to “re-bundle” billed charges that have been unbundled and to review claims for medical necessity determination prior to payment. Only services that are medically necessary and covered by the plan will be considered for payment.

Providers must submit a claim for services, regardless of whether the co-payment, deductible, or coinsurance from the member has been collected.

Electronic Claim Submission

True Health New Mexico understands how important it is for claim submissions to be processed timely and accurately. The quickest and most efficient way to file claims is electronically. If your office is not currently submitting claims electronically, True Health New Mexico encourages you to do so. Electronic claim submission offers a number of benefits for a provider’s office, including:

- Streamlined billing, which helps reduce paperwork;
- Faster claim delivery to True Health New Mexico instead of traditional mail delivery time;
- Improved feedback/correction capability for claims with missing or invalid data;
- One address for all True Health New Mexico claim submissions;
- Receipt acknowledging proof of acceptance by True Health New Mexico; and
- Quicker response/payment time for claims.

Payer IDs for Electronic Claims Submissions

Benefit Plans	Payer ID
Individual Plans	82288
Small Group Plans	82288
Large Group Plans	82288
Albuquerque Public Schools	85600
Federal Employee Health Benefits	85824

True Health New Mexico uses Availity as its electronic data interchange (EDI) vendor. Providers should work with their clearinghouse to ensure they can file to Availity.

Paper Claims Submission



Although True Health New Mexico highly recommends filing claims electronically, provider offices can help timeliness and accuracy of paper claims filing by adhering to the following guidelines when completing and submitting paper claims:

- Use the current CMS-1500 or the current UB04 claim form as appropriate when submitting paper claims that are compliant with the National Provider Identifier (NPI) and HIPAA regulations.
- Generally, the CMS-1500 form is used for professional services and the UB04 is used for facility services.

Please use original claim forms as opposed to copies of the forms.

- Make sure that all the fields are completed accurately. This will help avoid returned claims due to missing information.
- Refer to the member's current identification (ID) card to help ensure you have the appropriate member ID number as well as the correct address for submitting claims.
- Use machine/computer generated printed forms. True Health New Mexico **will not** accept handwritten claims.
- Claims with altered information or markings will not be accepted for consideration.
- When submitting attachments or documents that are to be considered as part of the claim processing, please include the member's ID number on each page.

All paper claims for **Individuals and Small and Large Groups** must be submitted to:
True Health New Mexico
P.O. Box 211468
Eagan, MN 55121

All paper claims for **Federal Employee Health Benefits** must be submitted to:
True Health New Mexico
P.O. Box 37200
Albuquerque, NM 87176

Claims Coding

Industry standard will be applied to claims based on:

- CPT definitions or guidance
- CMS guidance (including, but not limited to Correct Coding Initiatives (CCI))
- Specialty society guidance
- Clinical consultant network – industry/specialty-specific subject matter experts
- Health Plan Policy (HPP) – Health Plans concur that these edits are consistent with current health plan policies.

It is not uncommon for CPT, Revenue, HCPCS, and/or ICD-10 codes to be added, deleted, or modified. Providers are encouraged to keep track of such changes and ensure that claims are submitted with valid codes. Any claims submitted with invalid CPT, HCPCS, or ICD-10 codes may be rejected for payment. ICD-10 codes requiring fourth and fifth digits must be indicated on



claims. Additionally, appropriate modifiers should be included on claim submissions when applicable.

When a miscellaneous code must be used to identify a procedure, providers must include an explanation and/or the surgical procedure or operative notes supporting the use of the code. For miscellaneous or temporary pharmaceutical codes, providers must include the NDC number, drug name, and dosage and/or a copy of the invoice in order for the claim to be considered for payment.

Checking Claims Status

True Health New Mexico is required to process clean claims upon receipt within thirty (30) days for electronic submissions and forty-five (45) days for paper submissions. Providers will receive an Explanation of Payment (EOP) for all claims received. Claims may be rejected or be returned to the provider prior to acceptance into the claims system. Various reasons may cause this to occur; the most common being incomplete claims, invalid codes, electronic clearinghouse problems, or claims sent to the wrong address.

True Health New Mexico recognizes that there are a variety of reasons that may prevent a claim from entering the claims system to be processed. Therefore, if a provider submits a claim to True Health New Mexico and True Health New Mexico has not provided an Explanation of Payment (EOP) within the timeframes stated above, it is important for the provider to follow up with True Health New Mexico to check status of the claim(s) in question. Claims that are not followed up by provider within required time periods will not be processed for payment.

Providers should follow up at least every 30 days when checking status of any outstanding claims to ensure that both True Health New Mexico and providers identify and communicate issues preventing processing are resolved timely, so claims may be processed.

Any claims submitted outside the timely filing requirements as noted above will not be considered for payment unless the provider has documented proof of timely follow-up at least monthly from the date claim was submitted to True Health New Mexico.

Providers can verify claim status with True Health New Mexico in the following ways:

- Log in to the Provider Portal at truehealthnewmexico.com/providers/.
- Complete and fax the True Health New Mexico Claims Inquiry Form to (312) 548-9943.
- Contact True Health New Mexico Customer Care to check the status of claims. Customer Care can be reached 8:00 a.m. to 5:00 p.m. MST at 1-844-508-4677. Calls are limited to five (5) claims inquiries per call.

Claim Payment Disputes (Re-assessment and Adjustment Requests)

True Health New Mexico defines a payment dispute as a dispute claiming that payment was not made at the contractual rate. The dispute is also known as a re-assessment and/or adjustment request.



It is the responsibility of the provider offices to immediately post/track all claim payments and/or denials based on the Explanation of Payment (EOP) provided. It is not uncommon for a provider to request reassessment or adjustment following the processing of a claim(s). There are a variety of reasons that providers may request a reassessment or adjustment.

Some examples included are:

- Corrected claims
- Proof of timely filing
- Calculation of units billed
- Claim was submitted and paid twice
- Claim was paid at the wrong rate (contractual)
- Claim was paid for the wrong date(s) of service(s)
- Claim was paid at a wrong level of care
- Services were span billed with overlapping days on more than one claim
- A compliance audit was conducted
- Post payment recoveries
- Authorization was not applied accurately

However, regardless of the reason for the payment dispute, providers must comply with the following timeframes and processes when submitting these requests:

- The request must be made in writing within 180-days after the date the claims were originally paid.
- Requests for reassessment and adjustments can be made to Customer Care, 8:00 a.m. to 5:00 MST, at 1-844-508-4677 or by utilizing the Claim Reassessment/Adjustment Request Form.
- Access the Claim Reassessment / Adjustment Request Form to submit and expedite the request. Find the form at truehealthnewmexico.com/provider-forms-and-other-resources/.

Corrected claims are handled as indicated below:

- **Electronic adjustments for corrected claims** – Service Loop CLM 05/03 Frequency Field “7” (I – Institutional or P – Professional) – this indicator will allow for an electronic claim adjustment.
- **Paper** – Providers file CMS-1450 or CMS-1500 paper forms to P.O. Box 211468, Eagan, MN 55121. Providers must include any of the required/supporting documentation such as EOB, Original Paper Claim Form, and Clinical Documentation (if applicable).

Common Claim Errors

- Missing, expired or misused, CPT, ICD-10, HCPCS, or Revenue codes;
- No Explanation of Benefits (EOB) submitted when the member has other insurance coverage or Medicare primary coverage;
- Missing anesthesia time;



- Itemized statement is not attached;
- Missing place of service, type of service, or bill type;
- Incorrect or missing member ID number;
- Missing NPI number (Rendering and/or Billing); and
- Incorrect date of birth for the patient.

Coordination of Benefits

Occasionally, claims for services rendered to members are the primary responsibility of other payors. Providers are requested to assist True Health New Mexico to maximize recoveries under coordination of benefits or subrogation and bill services to the responsible primary payor. For coordination of benefits, True Health New Mexico requires an explanation of payment (EOP) from the primary payor before considering payment of claims when we are secondary. If the EOP is not attached, the claim will be denied with the request of this additional information.

In cases in which True Health New Mexico is the secondary payor, claims must be filed ninety (90) days from the date of service or ninety (90) days from the date that the Provider receives notice of payment decision from the primary payor, whichever is later.

Please attach a copy of the primary payor's EOP to the submitted claim. EOPs are also required for services denied by the primary payor and should be submitted to True Health New Mexico for consideration. Any claims submitted without the primary payor's EOP will be denied with a request for the additional information.

True Health New Mexico follows the National Association of Insurance Commissioners (NAIC) Coordination of Benefits Model rules in determining which payor's plan is primary and which is secondary.

Subrogation

True Health New Mexico conducts subrogation investigations for services that may indicate third-party liability. When the member or provider receives money to compensate for medical or hospital care for injuries or illness caused by another party, True Health New Mexico must be reimbursed for any expenses that may have paid in connection to the incident. If the member or provider does not seek damages, the provider must agree to allow True Health New Mexico to attempt recovery. For more information regarding subrogation policies and procedures, please contact Customer Care at 1-844-508- 4677.



PROVIDER APPEALS AND GRIEVANCES

True Health New Mexico takes provider and practitioner appeals and grievances (complaints) seriously. Provider appeals and grievances are processed timely to ensure a prompt and thorough investigation in alignment with federal and/or state regulatory requirements.

Definitions

Appeal: A dispute regarding the denial of payment for a claim in whole or in part.

Grievance: As defined by the OSI, a concern on behalf of the provider regarding:

- The operation of the health plan, including concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the plan's provider network; or
- The existence of adequate cause to terminate a provider's participation with the health plan to the extent that the relationship is terminated for cause.

Contracted Provider Appeals

When submitting appeals challenging the denial of a claim in whole or part, providers must file an appeal request within 180 days from the date of the initial Explanation of Payment (EOP) denial. Appeals must be submitted in writing following claims processing and receipt of a formal, written denial from True Health New Mexico.

True Health New Mexico allows contracted providers two levels of appeal review.

- **Level One Appeal:** Requests for appeal are reviewed and a determination made within 60-days from the date of receipt by True Health New Mexico.
- **Level Two Appeal:** If a provider is not satisfied with the outcome of the initial appeal review, the provider may request a level two appeal review. The provider must file the request for a level two appeal review within 30-days of the date of the level one decision. Requests received after the 30-day time period are not eligible for further review.

Please review the Reassessments/Adjustment Requests section of the [Claims Submission and Payment](#) Section of this handbook to determine if non-payment requires a reassessment or adjustment request or filing a formal, written appeal. Claim reassessment/adjustment requests submitted as appeals will be returned to the provider to submit via the appropriate claim reassessment/adjustment process.

Providers may file a written appeal by:

- Faxing True Health New Mexico at 1-800-747-9132, ATTN: Appeals & Grievances, **or**
- By writing:
True Health New Mexico
ATTN: Appeals
P.O. Box 37200 Albuquerque, NM 87176



Contracted Provider Grievances

Except where not applicable to the Member's benefit plan, True Health New Mexico processes and responds to provider grievances in accordance with the requirements outlined in the New Mexico Administrative Code, 13.10.16. A provider or practitioner may file a grievance regarding their concern with any aspect of True Health New Mexico's Plan of Operation, including concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of True Health New Mexico's provider network; or, the existence of adequate cause to terminate a provider's participation with a managed health care plan to the extent that the relationship is terminated for cause.

If a provider has a concern regarding the operation of the plan they may request, in writing, that the concern be reviewed by the True Health New Mexico Provider Reconsideration Committee. This committee shall consist of management and/or staff from various departments within True Health New Mexico such as the Director of Provider Services, Director of Claims and Enrollment, and a True Health New Mexico Medical Director.

The Reconsideration Committee reviews a provider's written grievance and sends a written response within 20-business days after True Health New Mexico obtains all necessary and pertinent information.

Providers may file a grievance by:

- Calling the Customer Care Center at 1-844-508-4677
- Faxing: 1-800-747-9132, ATTN: Appeals & Grievances
- Writing:
True Health New Mexico
ATTN: Grievances
P.O. Box 37200
Albuquerque, NM 87176

Office of Superintendent of Insurance Grievance Review (Commercial Claims ONLY)

Following this internal review, if the provider remains dissatisfied with the result of the internal grievance process, he/she may file a complaint with the OSI. The provider must file a written request with the OSI within 30-days from receipt of the written decision of the True Health New Mexico Provider Reconsideration Committee. Please contact us at 1-844-508-4677 for detailed information regarding our Provider Grievance program.

Appeal Process for Provider Terminations

Through a variety of sources, True Health New Mexico may discover that a practitioner has not met the standards of providing reliable, safe, quality care to those patients who are True Health New Mexico members. In these circumstances there is a range of actions True Health New Mexico may pursue to ensure the provision of safe and effective care, including review of the practitioner's current status with a variety of Boards or oversight bodies (e.g., the New Mexico Board of Medical Examiners), the implementation of a corrective action plan to address the



documented performance deficiency, or even the removal of the practitioner from the network, the latter referred to as “termination for cause.”

Termination for Cause: Providers should note that True Health New Mexico is required to notify appropriate authorities when it acts to limit, suspend, or terminate a practitioner’s participation in the network. True Health New Mexico does offer a practitioner the opportunity to appeal such adverse participation decisions.

Termination Without Cause: For a variety of reasons, True Health New Mexico may end its contractual relationship with a provider solely based on business needs, referred to as “termination without cause.” Terminations without cause may include the periodic removal of a practitioner from the True Health New Mexico network when there are more practitioners than needed to meet True Health New Mexico’s accessibility and availability standards. Such terminations are not related to practitioner performance, quality of care or service, or a material breach of contract. Nor are terminations without cause subject to an appeal process. For detailed information regarding our policy and procedures regarding provider terminations, please visit the [Provider Appeals and Grievances section](#) of this handbook or contact Provider Services at 1-844-508-4677.



MEMBER COMPLAINTS AND APPEALS

True Health New Mexico takes member complaints, in the form of grievances and appeals, seriously. Complaints are an important mechanism for identifying concerns and dissatisfaction among our membership. Member grievances and appeals are processed to ensure a timely and thorough investigation and according to federal and/or state regulatory requirements, as well as accreditation standards of the National Committee for Quality Assurance (NCQA).

Members have the right to file an appeal if they disagree with a True Health New Mexico decision to deny a service, in whole or in part. Members may also file a grievance related to our administrative practices, such as those decisions that appear to affect the availability, delivery or quality of health care services, including but not limited to claims payment or termination of coverage.

A complaint may be filed by a member or another person authorized to do so by the member. The member should initially contact the Customer Care Center at 1-844-508-4677. A Customer Care Center representative will make every effort to resolve the member's complaint to his or her satisfaction the first time it is brought to our attention. If the Customer Care Center representative is unable to resolve the concern or complaint to the Member's satisfaction, the Member can request that a formal appeal or grievance be filed.

Members covered under a commercial plan have the right to request an external independent review by the New Mexico Office of Superintendent of Insurance.

For detailed information regarding member grievances and appeals, please contact True Health New Mexico:

Commercial Plan Members can visit our Member Rights and Responsibilities page of our website at truehealthnewmexico.com/member-rights-and-responsibilities/ or contact us at 1-844-508-4677.

Federal plan members may obtain detailed information regarding complaints and appeals by visiting truehealthnewmexico.com/federal-employees/.

Providers are encouraged to familiarize themselves with True Health New Mexico's Member Rights and Responsibilities.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of this Plan, you are entitled to certain rights when you access coverage. There are also certain responsibilities that you hold. It is important that you understand these rights and responsibilities.

As a Member of this Plan, you have the following rights:

- You have a right to detailed information about your Plan. This may include benefits and services that are covered or excluded from the Plan, and all requirements that must be followed for Prior approval and Utilization Review.
- You have a right to always have available and accessible services for Medically Necessary and covered services; including 24 hours per day, 7 days per week for urgent and emergency care services, and for other health care services as defined by the Evidence of Coverage or the Summary of Benefits and Coverage.
- You have a right to information about your out-of-pocket expense limitations, and an explanation of your financial responsibility for services provided to you.
- You have a right to be treated in a manner that respects your privacy and dignity.
- You have a right to participate with your Providers in making decisions about your health care.
- You have a right to receive an explanation of your medical Condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives from your Provider in a language that you understand, regardless of cost or your plan's benefits.
- You have a right to be informed about your treatment from your Participating Provider; to request your consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of the possible consequences of refusing such treatment. This right exists even if treatment is not a covered benefit or Medically Necessary according to the Plan. The right to consent or agree to treatment may not be possible in a medical emergency where your life and health are in serious danger.
- You have a right to voice Complaints, Grievances, or Appeals with the Plan or its regulatory bodies about the Plan and/or the care that we provide.
- You have a right to make recommendations regarding the Plan's Member Rights and Responsibilities policies.
- You have a right to receive assistance in a prompt, courteous, and responsible manner.
- You have a right to the confidential handling of all communication and information maintained by the Plan. Your written permission will always be required for the release of medical and financial information, except:
 - When clinical data is needed by health care Providers for your care;
 - When the Plan is bound by law to release information;
 - When the Plan prepares and releases data but without identifying Members; and
 - When necessary to support the Plan's programs or operations, including for payment and to evaluate quality and service.

- You have a right to be promptly informed of termination or changes in benefits, services, or Participating Providers.
- You have a right to know, upon request, of any financial arrangements or provisions between the Plan and its Participating Providers, which may restrict referrals or treatment options or limit the services offered to you.
- You have a right to receive an explanation of why a benefit is denied; the opportunity to appeal the denial decision; the right to a second level of appeal with the Plan; and the right to request help from the New Mexico Superintendent of Insurance.
- You have a right to adequate access to health care providers near your home or work within the Plan's service area.
- You have a right to receive detailed information about requirements that you must follow for prior approval of certain services.
- You have a right to have access to a current list of Participating Providers in the Plan's network.
- You have the right to an example of the financial responsibility incurred by a Covered Person for services received from an Out-of-Network or Non-Participating Provider.
- You are responsible for learning how your Plan works. You should carefully read and refer to your Member Handbook and your Summary of Benefits and Coverage. Contact the Customer Care Center if you have questions or Concerns about your Plan.
- As a Member of the Plan, you have the following responsibilities:
- You have a responsibility to provide honest and complete information to the Plan and to your Providers.
- You have a responsibility to read understand the information that you receive about your Plan.
- You have a responsibility to know the how to properly access coverage and utilize your Plan.
- You have a responsibility to understand your health problems and participate in developing treatment goals that you agree to with your Providers.
- You have a responsibility to follow plans and instructions for care that you have agreed to with your Providers.
- You have a responsibility to present your Plan ID card before you receive care.
- You have a responsibility to promptly notify your Provider if you will be delayed or unable to keep an appointment.
- You have a responsibility to pay your applicable Deductible, Copayment, and Coinsurance amounts, including those for missed appointments.
- You have a responsibility to express your opinions, Concerns or Complaints in a constructive way to the Plan or to your Provider.
- You have a responsibility to inform the Plan and/or your Employer of any changes in family size, address, phone number or Membership status within thirty (30) calendar days of the change.
- You have a responsibility to make Premium payments on time if they are not paid directly by your Employer.



- You have a responsibility to notify the Plan if you have any other insurance coverage.
- You have a responsibility to follow the Plan's Complaints and Appeals process when you are dissatisfied with the Plan or a Provider's actions or decisions.

CLAIMS & ELIGIBILITY QUICK REFERENCE GUIDE

Paper Submissions	Individual, small, group, and large group claims	True Health New Mexico P.O. Box 211468 Eagan, MN 55121	<ul style="list-style-type: none"> Filing deadline is 90 days from the date of service. Professional services (CPT) must be submitted on a CMS-1500 claim form. Inpatient services must be submitted on a UB-04 claim form. Handwritten submissions will be rejected. Do not use labels, stickers, or stamps on the claim form. Do not send duplicate copies of any forms or supporting information.
	Federal employee claims	UPDATED NOVEMBER 2022! True Health New Mexico P.O. Box 37200 Albuquerque, NM 87176	
Electronic Submissions	Individual, small, group, and large group claims	NEW IN 2022! Member ID Prefixes: 700, TH0, 600, GS8 Group IDs: THNMHIX, THINDOFF01, 500 (SHOP prefix), GT0 (small group & large group prefix)	Payer ID for individual, small, and large groups: 82288
		NEW IN 2022! Member ID Prefix: GS8 Group ID: GTAPS01	Payer ID for Albuquerque Public Schools: 85600
	All claim types		<ul style="list-style-type: none"> X12 837 format is accepted. Version 5010 compliance required.
Claim Status Inquiries	True Health New Mexico	Customer Service: 844-508-4677	Limited to five claim inquiries per call.
Claim Re-Assessment/ Adjustment Form	Submit re-assessment and adjustment requests using the form located at truehealthnewmexico.com/provider-forms-and-other-resources .	True Health New Mexico P.O. Box 211468 Eagan, MN 55121	Access forms via the Provider Portal or at truehealthnewmexico.com/provider-forms-and-other-resources .
Appeal and Grievance Submissions	Submit appeals and grievances using the form located at truehealthnewmexico.com/member-forms .	True Health New Mexico P.O. Box 37200 Albuquerque, NM 87176	Access forms via the Provider Portal or at truehealthnewmexico.com/member-forms .

MEMBER ELIGIBILITY & PRIOR AUTHORIZATIONS		
Member Eligibility Verification	<ul style="list-style-type: none"> Online: truehealthnewmexico.com Telephonically: Eligibility Verification Line (IVR) or Customer Service 1-844-508-4677 Paper identification forms Member ID card 	
Prior Authorization	Contact True Health New Mexico's Medical Management Department: Phone: 1-844-508-4677 Fax: 1-866-446-3774	<ul style="list-style-type: none"> Members are required to have in-network primary care providers. Referrals to in-network specialists DO NOT require prior authorization. Prior Authorization request form and additional information is available at truehealthnewmexico.com.
PHARMACY SERVICES		
Contact True Health New Mexico Pharmacy Services at 1-866-823-1606 or by fax at 1-866-718-7938.		
VISION CLAIMS		
Contact VSP at 1-800-877-7195.		
OTHER RESOURCES		
Provider Services	1-844-508-4677	Provider Services is available to provide-assistance and answer questions Monday-Friday, 8:00 a.m.-5:00 p.m.

ACCESSING THE TRUE HEALTH NEW MEXICO PROVIDER DIRECTORY

Note to our Native American members: IHS, 638, and other tribal health facilities will be included at in-network rates, even if they are not listed as part of our network.

TIPS:

- First, select either the “Provider” or “Facility” button at the top left of the search screen.
- If you are searching for an Emergency Room, select “Hospitals.”
- Enter part of the provider’s first or last name to expedite your search.
- Always enter a zip code and select a value from the “within” drop-down menu.
- Be sure to select an option from the “Specialty” drop down menu, even when searching for a PCP.

Provider Search:

Search by specialty

- Choose a provider type from the drop-down menu, such as Any Type, Alternative Medicine Provider, Behavioral Health Provider, Pediatric Specialist, Primary Care Provider (PCP), or Specialist.
- You may narrow your results further by selecting a specialty for your provider type from the Specialty drop-down menu.
- If you are looking for a provider affiliated with a particular hospital, select a hospital from the Hospital Affiliation drop-down menu.
- You may enter a name of a medical group in the Medical Group field. Leave this field blank to broaden your search results.

Search by provider detail

- You may use this option to search only for PCPs, providers of a particular gender, providers who are accepting new patients, providers who speak certain languages, or to search by a provider’s name.

Search by location

- You may search for a provider within 5- to 50-mile range; only inside a zip code, city, state, or county; or by zip code, city, state, and/or county.
- The results will provide you with a Google map to assist you in locating your provider.

Hospital affiliation, medical group affiliation, and board certification

Information such as a provider’s hospital affiliations, medical group affiliations, specialty, and board certification are listed on the search results page and the details page. You can reach the details page by selecting the provider’s name on the results page.



Facility Search

Search by location

- You may search for a facility within a 5- to 50-mile range; only inside a zip code, city, state, or county; or by zip code, city, state, and/or county.

Search by specialty

- You may search by type of facility or type of service.
- You also may enter the name of a facility in the Facility Name field. Leave this field blank to broaden your search results.

Directory and Data Validation

True Health New Mexico updates its data within 30 calendar days of receiving new information from either source, and provides the source, frequency of validation, and limitations for each of the following:

- **Name/address/phone:** Except where noted, all information about this provider's name, gender, hospital affiliation, office location, languages, and acceptance of new patients is self-reported by the provider. True Health New Mexico updates this information only upon the provider's request. True Health New Mexico validates the accuracy of this information at least annually.
- **Specialty:** Specialty is self-reported by the provider and verified during credentialing when he or she first joins the network. The doctor verifies his or her training in the specialty or his or her board certification status. True Health New Mexico validates the accuracy of this information at least annually and formally during the credentialing process every three years.
- **Additional locations:** If the provider has additional offices, the directory will list them. True Health New Mexico validates the accuracy of this information at least annually and formally during the credentialing process every three years.
- **Board certification:** Board certification is voluntary. A board-certified doctor, after completing residency training in his or her specialty, has passed an exam and has met all the requirements established by the board. The American Board of Medical Specialties or the American Osteopathic Association verifies this information when the doctor first joins the network and at least every three years thereafter. You can verify the doctor's current board status by visiting www.abms.org. Members can check the most current board certification status of a provider by going to the ABMS, American Medical Association, or AQA websites. True Health New Mexico validates the accuracy of this information at least annually and formally during the credentialing process every three years.
- **Hospital affiliation:** Hospital affiliation displayed on this page doesn't necessarily indicate that the hospital is in-network. Please conduct a hospital search to confirm the hospital is in-network for your benefit plan. True Health New Mexico validates the accuracy of this information at least annually and formally during the credentialing process every three years.



- **Medical group affiliation** (if applicable): True Health New Mexico validates the accuracy of this information at least annually and formally during the credentialing process every three years.

The following providers are included in our provider directory for all plans and metal levels: All of True Health New Mexico health plans are designed based on specific criteria, as well as New Mexico state regulatory criteria that applies to select participating primary care providers and providers across the following specialties.

Additional specialists are included if they meet our credentialing requirements to ensure members have access within a reasonable distance to the number and types of providers needed. Specialists as noted within the grid include those that meet minimum standards for clinical quality measures.

Type	Specialty	
Physician	Doctor of Osteopathy	Medical Doctor
Allied Professional	Acupuncturist	Doctor of Naprapathy
	Anesthesiology Assistant	Doctor of Oriental Medicine
	Audiologist	Occupational Therapist
	Certified Diabetic Educator	Optometrist
	Certified Nurse Midwife	Oral Maxillofacial Surgeon
	Certified Nurse Practitioner	Oral Surgeon
	Certified Physician Assistant	Physical Therapist
	Certified Registered Nurse Anesthetist	Podiatrist
	Chiropractor	Registered Dietician
	Dentist	Speech Therapist/Pathologist
Behavioral Health	Doctor of Osteopathy	Medical Doctor (Psychiatrist)
	Alcohol & Drug Abuse Counselor	Certified Psych Nurse Specialist
	Clinical Psychologist	Marriage/Family Therapist
	Professional Art Therapist	Social Worker

Note: True Health New Mexico’s selection criteria for hospitals and our selection criteria for providers is the same for all plans, whether purchased on or off the exchange.

The following facility and ancillary providers are included in True Health New Mexico’s provider directory for all plans and metal levels:



Facility & Ancillary Provider Types
Air Ambulance Facilities
Ambulatory Surgical Center (Freestanding) Behavioral Health: Ambulatory Center
Behavioral Health: Hospital and Partial Hospitalization Program Behavioral Health: Substance Use Disorder Rehabilitation Facility Birthing Center
Durable Medical Equipment Provider
Free-Standing Radiology Centers: MRI, Mammography, CT, X-Ray, Ultrasound Home Health Agencies
Hospice Provider
Hospital: Acute Care, Rehabilitation, Long-Term Care, Children’s Infusion Center
Laboratories: Pathology, Clinical, Genetic, Drug Testing, Draw Stations Prosthetics and Orthotics
Skilled Nursing and Long-Term Care Facility Sleep Study Center
Urgent Care Centers

How Hospitals are selected for the True Health New Mexico Network

All True Health New Mexico health plans and metal levels (e.g., Gold, Silver, Bronze), both on and off the Exchange, provide members with access to hospitals that were selected based on specific criteria.

First, True Health New Mexico looks at the number of hospitals in the counties where the plan provides coverage to members. True Health New Mexico makes sure that members can access hospitals within a reasonable distance and drive time.

When choosing hospitals to include in all plans and metal levels, True Health New Mexico also reviews the performance of hospitals using the following measures from nationally recognized sources such as The Joint Commission, CMS Medicare, and The Leapfrog Group.

Note: True Health New Mexico’s selection criteria for hospitals and selection criteria for providers is the same for all plans, whether purchased on or off the exchange.



NOTICE OF PRIVACY PRACTICES

Privacy Commitment

Thank you for giving True Health New Mexico the opportunity to serve you. In the normal course of doing business, True Health New Mexico creates records about you and the treatment and services you receive from medical providers. The information we collect is called **Protected Health Information (PHI)**. True Health New Mexico is committed to maintaining and protecting your privacy. We are required by federal and state law to protect the privacy of your PHI and to provide you with this Notice about how we safeguard and use it. You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will promptly provide you with a paper copy.

When we use or disclose your PHI, we are bound by the terms of this Notice. This Notice applies to all oral, electronic, or paper records we create, obtain, and/or maintain that contain your PHI.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

How We Protect Your Oral, Written, and Electronic Information

We understand the importance of protecting your PHI. We restrict access to your PHI to authorized workforce members who need that information for your treatment, for payment purposes and/or for health care operations. We will not disclose your PHI without your authorization unless it is necessary to provide your health benefits, administer your benefit Plan, support Plan programs or services, or as required or permitted by law. If we need to disclose your PHI, we will follow the policies described in this Notice to protect your privacy.

True Health New Mexico protects your PHI by following processes and procedures for accessing, labeling, and storing confidential records. Access to our facilities is limited only to authorized personnel. Internal access to your PHI is restricted to Plan employees who need the information to conduct Plan business. We train our workforce members on policies and procedures designed to protect you and your privacy. Our Privacy Officer monitors the policies and procedures and ensures that they are being followed and arranges for new hire and annual training on this important topic.

Notice of Confidentiality of Domestic Abuse Information

The Domestic Abuse Insurance Protection Act (DAIPA) is a state confidentiality law. It protects a member's confidential information if he or she is or has been involved in domestic abuse. This act regulates insurers' and insurance support organizations' use of confidential abuse information.

In processing your application for insurance or a claim for insurance benefits, we may receive confidential domestic abuse information from sources other than you. If this happens, we are



prohibited from using it or any other confidential abuse information, or your status as a victim of domestic abuse as a basis for:

- Denying or refusing to insure, renewing or reissuing, canceling, or otherwise terminating (ending) your health care coverage.
- Restricting or excluding coverage.
- Charging a higher premium for health coverage.

You have the right to access and correct all confidential domestic abuse information we may have about you. You have the right to inform us of your wish to be designated as a protected person. As a protected person, confidential information, such as your address and phone number, will remain confidential. We will disclose and transfer it only in accordance with state and federal laws.

If you wish to be designated as a protected person, please contact True Health New Mexico at (505) 633-8020 or 1-844-508-4677.

How We Use and Disclose Your Confidential Information

We may disclose your PHI without your written authorization if necessary while providing your health benefits. We may disclose your PHI for the following purposes:

- **Treatment.** We may disclose your PHI to your health care provider for plan coordination; to help obtain services and treatment you may need; or to coordinate your health care and related services.
- **Payment.** We may use and disclose your PHI to make coverage determinations; to obtain payment of premiums for your coverage; and to determine and fulfill our responsibility to provide your benefits. However, we are prohibited from using or disclosing genetic information to make any coverage determinations, such as eligibility or rate setting. We may also disclose your PHI to another health plan or a health care provider for its payment activities.
- **Health Care Operations.** We may use and disclose your PHI for our health care operations, such as providing customer service; to support and/or improve the programs or services we offer you; or to assist you in managing your health. We may also disclose your PHI to another health plan or a provider who has a relationship with you so that it can conduct quality assessment and improvement activities.
- **Appointment Reminders and Treatment Alternatives:** We may use and disclose your PHI for appointment reminders or send you information about treatment alternatives or other health-related benefits and services. You will have an opportunity to opt out of future communications.
- **Disclosure to Plan Vendors and Accreditation Organizations.** We may disclose your PHI to companies with whom we contract if they need the information to perform the services they provide to us. We may also disclose your PHI to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Healthcare Effectiveness Data and Information Set (HEDIS®) data for quality

measurement purposes. When we enter into these types of arrangements, we obtain a written agreement to protect your PHI.

- **Public Health Activities.** We may use and disclose your PHI for public health activities authorized by law, such as preventing or controlling disease, reporting child or adult abuse or neglect to government authorities, or to close friends or family members who are involved in or help pay for your care. We may also advise your family members or close friends about your condition or location (such as that you are in the hospital).
- **Health Oversight Activities.** We may disclose your PHI to a government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance.
- **For Research.** We may disclose your PHI for research purposes, subject to strict legal restrictions.
- **To Comply with the Law.** We may use and disclose your PHI as required by law.
- **Judicial and Administrative Proceedings.** We may disclose your PHI in response to a court or administrative order and, under certain circumstances, a subpoena, warrant, discovery request, or other lawful process.
- **Law Enforcement Officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law in compliance with a court order, warrant, or other process or request authorized by law to report a crime or as otherwise permitted by law.
- **Health or Safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the general public or other person.
- **Government Functions.** Under certain circumstances, we may disclose your PHI to various departments of the government such as the U.S. military or the U.S. Department of State.
- **Workers' Compensation.** We may disclose your PHI when necessary to comply with Workers' Compensation laws. State law may further limit the permissible ways we use or disclose your PHI. If an applicable state law imposes stricter restrictions, we will comply with that state law.

Uses and Disclosures with Your Written Authorization

We will not use or disclose your PHI for any purpose other than the purposes described in this Notice without your written authorization. The written authorization to use or disclose health information shall remain valid, which in no event shall be for more than twenty-four (24) months. You can revoke the authorization at any time.

Your Individual Privacy Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities.

- **Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of your PHI for the treatment, payment, and health care operations purposes



explained in this Notice. This may be done by means of an oral, written, or electronic request from you. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. If we do agree to the restrictions, we will abide by them.

- **Right to Receive Confidential Communications.** You may ask to receive communications of your PHI from us by alternative means of communication or at alternative locations, if you believe that communication through normal business practices could endanger you. While we will consider reasonable requests carefully, we are not required to agree to all requests. Your request must specify how or where you wish to be contacted.
- **Right to Inspect and Copy Your PHI.** You may ask to inspect or to obtain a copy of your PHI that is included in certain records we maintain. Under limited circumstances, we may deny you access to a portion of your records. If you request copies, we may charge you copying and mailing costs consistent with applicable law. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format.
- **Right to Amend Your Records.** You have the right to ask us to amend your PHI that is contained in our records. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your doctor or another person created the information that you want to change, you should ask that person to amend the information.
- **Right to Receive an Accounting of Disclosures.** Upon your oral, written, or electronic request, you may obtain an accounting of disclosures we have made of your PHI, except for disclosures made for treatment, payment, or health care operations; disclosures made earlier than six years before the date of your request; and certain other disclosures that are exempted by law. If you request an accounting more than once during any 12-month period, we may charge you a reasonable fee for each accounting statement after the first one.
- **Right to Receive a Paper Copy of this Notice.** You may contact Customer Care at the number on your Plan ID card to obtain a paper copy of this Notice.
If you wish to make any of the requests listed above under Your Individual Privacy Rights, you must notify the Plan in writing.

For More Information or If You Have Complaints

If you have any questions about your privacy rights, believe that True Health New Mexico has violated your privacy rights or disagree with a decision that we made about access to your PHI, or if you want more information about your privacy rights or do not understand your privacy rights, you may contact our Privacy Officer at the following address or telephone number. If we discover a breach involving your unsecured PHI, we will notify you of the breach by letter or other method permitted by law.

Privacy Officer

You may contact our Privacy Officer at True Health New Mexico P.O. Box 37200, Albuquerque, NM 87176 or by phone at (505) 633-8020.



If you believe True Health New Mexico may have violated your privacy rights, you may also file a written complaint with the Secretary of U.S. Department of Health and Human Services, (HHS). Your complaint can be sent by email, fax, or mail to the HHS' Office for Civil Rights (OCR). You can file a written complaint to: U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W. Washington, D.C. 20201, or by calling 1-800-368-1019. For more information, go to the OCR website: hhs.gov/ocr/privacy/hipaa/complaints.

We will not take any action against you if you exercise your right to file a complaint with us or the Secretary.

We may change the terms of this Notice at any time, and we may, at our discretion, make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice. The new Notice will be available upon request, on our website, and we will mail a copy to you.

LINKS TO IMPORTANT FORMS & OTHER RESOURCES

Description and Hyperlink
Individual Health Plan Documents
Small Group Plan Documents
Large Group Plan Documents
Pharmacy-Formulary
Case Management Services
Disease Management Services
Contracting with Us
Prior Authorization Requests
Provider Forms & Other Resources , including: Claim Reassessment/Adjustment Form Claims Inquiry Form Claims Refund Form Complex Case Management Referral Form Coordination of Care Form EFT Authorization Agreement Inpatient Notification Form Payment Appeal Request Form
Transition of Care Guide and Form
Attestation: Decision Making & Compensation
Claims & Eligibility Quick Reference Guide
Preventive Health Guidelines
Prior Authorization List and PA Request Form (Pharmacy and Medical)
Provider Services Contact List



HMO PLANS: SMALL AND LARGE GROUP ID CARD SAMPLE

		[Plan Name]
Subscriber Name:	PCP	[PCP Copay]
Group ID#:	Specialist	[Specialist Copay]
Subscriber ID#:	Urgent Care	[Urgent Care Copay]
	Emergency Room	[ER Copay]
	RX	[RX Copays]
RXBIN: 004336		
RXPCN: ADV		
RXGRP: [RXGRP]		Electronic Claim Payor ID: 82288

Benefits are administered by True Health New Mexico. This card does not guarantee coverage. Refer to your Summary of Benefits of Coverage and Evidence of Coverage Handbook for additional information regarding your plan.

Customer Service	(844) 508-4677
Pharmacy Customer Service	(866) 341-8561
TTY Services provided by AT&T TTY Line	(800) 659-8331
Care Connect Line (Nurse Advice)	(844) 308-2552

If you have a complaint about the coverage under your health plan, you may contact:
 Managed Health Care Bureau
<https://www.osi.state.nm.us/ManagedHealthCare/contactus.aspx> (855) 427-5674

Medical Paper Claims: True Health New Mexico, P.O. Box 211468, Eagan, MN 55121	
Medical Prior Approval/Prior Authorization	(844) 508-4677
Pharmacy Prior Approval/Prior Authorization	(866) 823-1606
Pharmacy Help Desk	(800) 364-6331
To find a MultiPlan provider for emergencies outside of service area	(888) 342-7427
THNM-PD-0313-1219	



PPO PLANS: SMALL AND LARGE GROUP ID CARD SAMPLE

	[Plan Name]
Subscriber Name:	PCP [PCP Copay]
Group ID#:	Specialist [Specialist Copay]
Subscriber ID#:	Urgent Care [ER Copay]
	Emergency Room [RX Copays]
	RX
RXBIN: 004336	
RXPCN: ADV	
RXGRP: [RXGRP]	Electronic Claim Payor ID: 82288

Benefits are administered by True Health New Mexico. This card does not guarantee coverage. Refer to your Summary of Benefits of Coverage and Evidence of Coverage Handbook for additional information regarding your plan.

Customer Service	(844) 508-4677
Pharmacy Customer Service	(866) 341-8561
TTY Services provided by AT&T TTY Line	(800) 659-8331
Care Connect Line (Nurse Advice)	(844) 308-2552


If you have a complaint about the coverage under your health plan, you may contact:
 Managed Health Care Bureau
<https://www.osi.state.nm.us/ManagedHealthCare/contactus.aspx> (855) 427-5674

Medical Paper Claims: True Health New Mexico, P.O. Box 211468, Eagan, MN 55121	
Medical Prior Approval/Prior Authorization	(844) 508-4677
Pharmacy Prior Approval/Prior Authorization	(866) 823-1606
Pharmacy Help Desk	(800) 364-6331
To find a MultiPlan provider for emergencies outside of service area	(888) 342-7427

THNM-PD0314-1219



FEDERAL PLAN SAMPLE ID CARD



True Health New Mexico HMO

Member Name: JEMIMA PUDDLE-DUCK	PCP	\$10
Group ID#: FEHB01	Specialist	\$30
Member ID#: FB00000452	Urgent Care	\$30
	Emergency Room	\$150
	RX	\$5/\$30/\$70/\$350/\$450

RXBIN: 004336
RXPCN: ADV
RXGRP: RX4142

Benefits are administered by True Health New Mexico. This card does not guarantee coverage. Refer to the Plan's FEHB Brochure for additional information.

Important Phone Numbers for Members

True Health New Mexico Customer Service	(844) 508-4677
Pharmacy Customer Service	(866) 341-8561
TTY Services provided by AT&T TTY Line	(800) 659-8331
Care Connect Line (Nurse Advice)	(844) 308-2552




To find a MultiPlan provider, visit multiplan.com.

Important Phone Numbers for Providers

Medical Prior Approval/Prior Authorization	(844) 508-4677
Pharmacy Prior Approval/Prior Authorization	(866) 823-1606

Electronic Claim Submission Payer ID: 85824
Submit Paper Claims to: True Health New Mexico, PO Box 930955,
Birmingham, AL 38283-0955

Help Desk for Pharmacies: (800) 364-6331

Update Appendix

Date	Summary	Page
September 2020	Updated reference guide to include the member ID and group ID formats for each payor ID.	54
November 2020	Corrected the address for filing a provider appeal.	47
January 2022	Updated the information about our parent company.	3
January 2022	Updated Compliance Hotline phone number.	5
January 2022	Updated Fraud, Waste, and Abuse hotline information.	10
January 2022	Updated the member ID card prefixes and group IDs. Removed claims fax number.	54
November 2022	Updated the Claims and Eligibility Reference Guide.	54
November 2022	Removed Change Healthcare and added Availity as new EDI vendor.	41-42
November 2022	Updated claims address for FEHB claims.	43
December 2022	Updated the Claims and Eligibility Reference Guide.	54