

Provider Handbook

UNM HEALTH
Insurance Plan

UNM Health Insurance Plan

Provider Reference Manual

Administered by Community Care Plan (CCP)

Effective Date	January 1, 2027
Plan Year	2027
Plan Sponsor	University of New Mexico Health (UNMH)
Plan Administrator	Community Care Plan (CCP)
Plan Type	Self-Insured Employee Health Plan

This manual is intended for use by contracted UNMHIP network providers. Contents are subject to change. Providers will be notified of significant updates.

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1 | CONTACT INFORMATION

Key Contacts and Phone Numbers

The following contacts are available to assist UNMHIP network providers with questions about eligibility, authorizations, claims, and administrative matters.

Contact / Department	Phone / Fax / Email	Purpose
Provider Operations Hotline	Phone: 1-855-819-9506 Email: ccp.provider@ccpares.org	General provider inquiries, and network participation
Claims Inquiries	Phone: 1-866-602-1751	Claims submission, status, disputes
Prior Authorization	Phone: 1-866-602-1751	Authorization requests and status
Case Management	Phone: 1-866-602-1751	Care coordination and case management referrals
Contracting & Credentialing	Email: Providers_UNMHealthInsPlan@salud.unm.edu	Contracting and credentialing
Fraud & Abuse Hotline	Phone: 1-888-419-3456	Report suspected fraud, waste, or abuse
Member Services	Phone: 1-866-602-1751	Member eligibility, benefits, ID cards
Provider Portal / Online Resource	Phone: 1-844-514-1494 Website: http://planlink.ccpcares.org/	Eligibility, auth, claims, portal access
Behavioral Health Services	For Prior Authorization: 1-866-602-1751 Crisis Support: NMCAL 1-855-NMCRISIS (1-855-662-7474)	Behavioral health prior authorizations, 24/7 crisis support
Pharmacy	Member Services: 833-559-5676 Help Desk: 833-716-2523	Pharmacy benefit, prior auth for medications
TelaDoc	Phone: 1-800-835-2362	Telehealth services

CCP Office Address

Community Care Plan (CCP)

1643 Harrison Parkway, Building H, Suite 200

Sunrise, Florida 33323

UNMH Office Address

UNM Health Insurance Plan

933 Bradbury Drive SE, HOPE Ste 3072

Albuquerque, NM 87106

2 | INTRODUCTION

Welcome

Thank you for participating in the UNM Health Insurance Plan (UNMHIP) network of physicians, hospitals, facilities, and professional providers. UNMHIP is a self-insured employee health plan sponsored by the University of New Mexico Hospitals (UNMH) and administered by Community Care Plan (CCP). Your participation in this network supports the health and well-being of UNMH employees and their eligible dependents.

This Provider Reference Manual is designed to serve as a comprehensive resource for your office. It outlines the policies, procedures, and administrative requirements that govern your participation in the UNMHIP network. We encourage you to review this manual thoroughly and share it with your billing and clinical staff.

Please check the CCP provider website and UNMHIP-specific communications for updates, forms, drug list information, medical policy updates, and other provider resources.

About UNM Health Insurance Plan

Plan History

The UNM Health Insurance Plan (UNMHIP); or Plan is an employer-sponsored, self-funded health benefit plan established by UNM Hospital to provide health care coverage for eligible employees and their eligible family members. Under a self-funded arrangement, UNM Hospital assumes financial responsibility for covered claims and establishes the Plan's eligibility requirements, benefit structure, cost-sharing provisions, limitations, and exclusions.

UNM Hospital partners with CCP as their third-party administrator (TPA) to perform administrative services on the Plan's behalf. These services may include claims processing, member support, utilization management, provider network administration, appeals support, and other operational functions.

Enrollment Overview

UNMHIP coverage is only available to employees who meet the eligibility requirements established by UNM Hospital, as well as eligible family members enrolled under the employee's coverage. Eligible family members may include a spouse or domestic partner and eligible dependent children, subject to the Plan's enrollment and documentation requirements.

Employees generally have an opportunity to enroll:

When they first become eligible for benefits;

During the annual Open Enrollment period; or

Following a qualifying life event or other special enrollment event permitted under the Plan.

Employees are responsible for completing enrollment requirements within the applicable timeframe and providing any documentation needed to verify dependent eligibility. UNM Hospital determines coverage effective dates, employee contributions, available coverage tiers, and the rules governing enrollment changes.

Key Distinguishing Features

UNMHIP is designed specifically for the UNM Hospital workforce and differs from a fully insured commercial health plan in several important ways:

Employer-sponsored and self-funded. UNM Hospital directly sponsors the Plan and funds covered claims, allowing the benefit program to be structured around the needs of its employees and their families.

Administered by CCP as their dedicated TPA. CCP manages many of the Plan's day-to-day administrative functions but does not insure the Plan. UNM Hospital remains the Plan sponsor and retains authority over the Plan's design and operation.

Comprehensive benefit structure. The Plan provides coverage for eligible medical, surgical, prescription drug, behavioral health, substance use disorder, preventive, emergency, and other covered health care services, subject to the terms of the applicable Plan documents.

Provider network focus. Members are encouraged to use participating providers to receive the highest available level of benefits and reduce potential out-of-pocket expenses. Certain services may require prior authorization or may be covered only when received from an eligible network provider.

Coverage for eligible family members. The Plan allows eligible employees to extend coverage to qualifying spouses, domestic partners, and dependent children in accordance with the Plan's eligibility and enrollment rules.

Employee-focused administration. The Plan is supported by UNM Hospital' Benefits Department and CCP provides members with resources for eligibility, claims, prior authorization, benefit, and appeal questions.

Plan sponsor flexibility. UNM Hospital may amend, modify, suspend, or discontinue Plan provisions in accordance with applicable law. Members will be informed of material changes through updated Plan documents or other official communications.

Plan Sponsor	University of New Mexico Hospital (UNMH)
Plan Type	Self-Insured Employee Health Plan
Plan Administrator	Community Care Plan (CCP)
Service Area	Albuquerque and surrounding counties
Eligible Members	UNMH employees and eligible dependents
Effective Date	1/1/2027

About Community Care Plan (CCP)

Community Care Plan (CCP), the health plan with a heart, was created in 2000 and is based in Sunrise, Florida. CCP is owned by two large, well-respected hospital systems Broward Health and Memorial Healthcare System. CCP serves members across Medicaid, Florida Healthy Kids (CHIP), self-insured employee health plans, 22Health marketplace plans, and uninsured programs (managed through SydCura, CCP's third-party administration division).

CCP maintains Health Plan and Health Outcomes accreditation by the National Committee for Quality Assurance (NCQA) and is also accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC).

Purpose of This Manual

This manual answers key questions about UNMHIP and how it works. It outlines the policies, procedures, and programs you have agreed to comply with under your Master Services Agreement (MSA) with UNM Health Insurance Plan. Please review this material to understand your role in providing services to UNMHIP members and complying with plan requirements. If you need a copy of your contract, please reach out to UNM Health Insurance Plan at Providers_UNMHealthInsPlan@salud.unm.edu

This manual and its contents are subject to change. Providers will be notified of significant updates through provider communications, newsletters, and the CCP provider website. The Plan will make best and reasonable efforts to notify providers at least thirty (30) calendar days prior to the effective date of any changes.

3 | MEMBER ELIGIBILITY

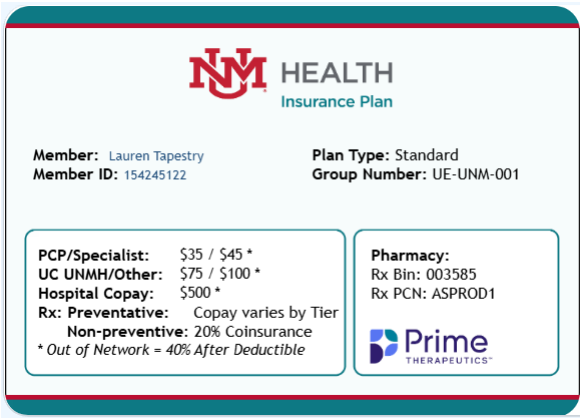
Eligibility Overview

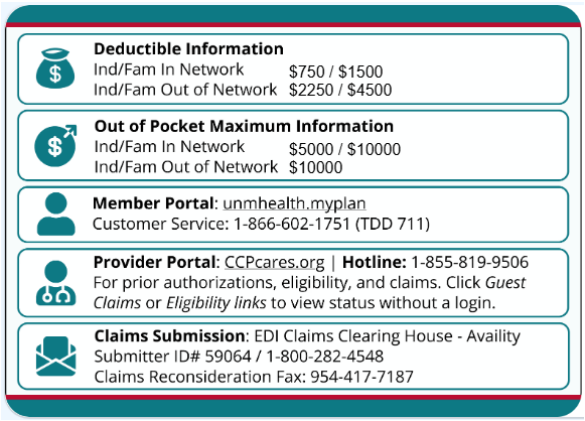
UNMHIP members include active employees of University of New Mexico Hospital (UNMH) and their eligible dependents who have enrolled in the UNMHIP benefit plan. Eligibility is determined by UNMH Human Resources and communicated to CCP.

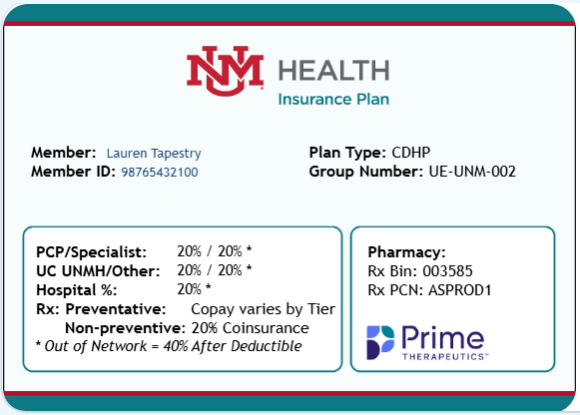
Providers should verify a member's current eligibility, coverage effective date, benefit plan, and applicable network before rendering nonemergency services. This overview is provided for reference and does not replace the governing Plan documents or eligibility information available through the CCP's provider portal or eligibility verification channels.

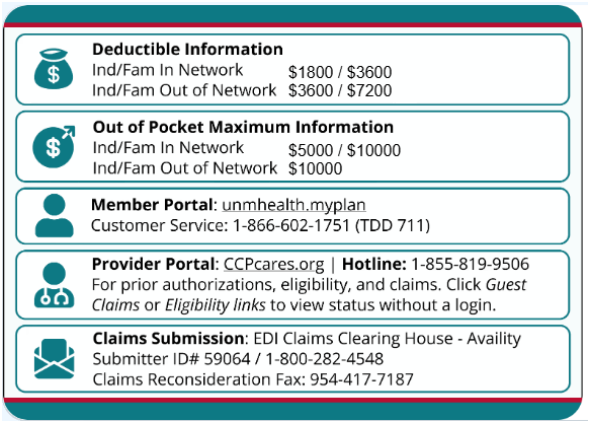
Member ID Cards

UNMHIP members will receive a member ID card identifying them as plan participants. Providers should request the member ID card at each visit to verify enrollment. Member ID cards samples are for illustrative purposes only and are subject to change.









Verifying Member Eligibility

Providers are responsible for verifying member eligibility prior to rendering services. Eligibility verification does not guarantee coverage or payment.

Methods to Verify Eligibility

- Provider Portal (PlanLink): Log in to http://planlink.ccpcares.org/ to confirm eligibility and benefits in real time.
- Phone: Member Services 1-866-602-1751

Member Benefits

Benefits and covered services are determined by the member's specific health plan and are subject to applicable plan provisions, limitations, and exclusions.

Providers are encouraged to review the applicable plan documents to understand covered benefits, member cost-sharing responsibilities, and any authorization requirements.

Current benefit documents, including Summaries of Benefits and Coverage (SBCs) and other applicable plan materials, are available on our website at CCPcares.org.

Provider should verify member eligibility and benefits prior to rendering services. Verification of benefits does not guarantee coverage or payment. All services area subject to the terms of the member's plan and applicable claims processing requirements.

Coordination of Benefits

When a UNMHIP member has other health coverage, UNMHIP may be primary or secondary depending on applicable coordination of benefits rules. Providers must identify and submit claims to the primary payer first. Submit any remaining balance with evidence of the primary payer's determination to the secondary payer.

The UNM Health Employee Medical Plan (UNMHIP) coordinates benefits when a member has coverage under more than one health plan. COB determines which plan pays first, or is primary, and which plan considers the remaining eligible charges as secondary. Combined payments from all applicable coverages may not exceed 100% of the Plan's covered charges.

Provider Billing Requirements

Providers should obtain information regarding all other coverage at each encounter and verify the correct primary and secondary payers before submitting a claim. When another plan is primary, the provider must

submit the claim to that plan first. As the claim submitted to CCP as the secondary payer, must include the primary payer's Explanation of Benefits or other payment determination.

Medicare and Other Liability Coverage

Medicare coordination is governed by applicable federal Medicare Secondary Payer requirements and may vary based on the member's employment status, age, disability, end-stage renal disease status, and reason for Medicare entitlement. Providers should verify the member's Medicare status and the applicable payer order before billing.

Claims involving automobile insurance, workers' compensation, third-party liability, or another responsible party must be billed in accordance with the applicable liability and reimbursement requirements and follow applicable federal/state requirements.

4 | NETWORK SERVICES & PROVIDER PARTICIPATION

Overview

CCP's Provider Operations Department is dedicated to building strong working relationships with UNMHIP network providers by offering:

- Information on UNMHIP products, benefits, and plan updates
- Claims support and reimbursement guidance
- Provider education and training resources
- Personalized provider representative contacts
- Accurate claims payment through maintenance of up-to-date provider information
- Guidance on policies, procedures, and regulatory compliance

Provider Representative

Each UNMHIP provider is assigned a Provider Representative who can assist with questions about contracting, reimbursement, education, and escalated issues. To find your assigned representative:

Utilize the "Find A Provider Representative" tool to identify the Provider Representative assigned to your practice, group, or facility.

Contracting

Contracting Process

To participate in the UNMHIP network, providers must execute a Master Services Agreement (MSA) with UNMHIP. The process includes submission of a provider interest form, credentialing review, and contract execution.

Contracting Process

Providers interested in participating in the UNM Health Insurance Plan (UNMHIP) network must complete the applicable contracting and credentialing requirements established by the UNMH Insurance Plan. Interested providers should complete the Provider Interest Form. Please submit the completed form via email to Providers_UNMHealthInsPlan@salud.unm.edu. Submission and acceptance of an email inquiry is not a guarantee that the interested provider will be offered a contract. Network participation is not effective until all required documentation has been received and approved, credentialing has been completed, and a fully executed provider agreement and effective date have been issued.

The contracting process may include submission of a participation request, provider demographic and ownership information, tax documentation, licensure and accreditation records, professional liability coverage, credentialing materials, service locations, specialties, and other information necessary to evaluate network participation. Providers must ensure that all submitted information is accurate, complete, and current to avoid delays.

Execution of a provider agreement does not automatically authorize every practitioner, facility, location, or service associated with the contracting entity. Provider offices should make all reasonable efforts to respond to UNM Health Insurance Plans requests quickly and completely to avoid delays in network participation. Each applicable provider and service location must be properly identified, credentialed, and loaded into CCP's systems before services are rendered as an in-network provider.

Providers may not represent themselves as participating in UNMHIP or bill services at contracted rates until written confirmation of participation and the effective date has been received. In unique circumstances and with the approval from both parties, UNMHIP may allow providers to act as an in-network provider under a Letter of Agreement (LOA) or Letter of Intent (LOI) before the MSA is fully executed. Providers acting as in-network providers under a Letter of Agreement or Letter of Intent are bound by the Plan rules and requirements unless otherwise stated in the LOA or LOI. Services rendered before the confirmed effective date may be processed as out-of-network and are not guaranteed to qualify for retroactive participation.

Following approval, participating providers are responsible to comply with the terms of their agreement, applicable credentialing and recredentialing requirements, utilization management and prior authorization procedures, claims submission standards, Provider Reference Manual requirements, and timely notification of changes to demographic, ownership, licensing, tax, or practice information.

Prohibited Contract Terms

UNMH does not include provisions in provider contracts that would:

- Offer financial or other inducements to provide fewer services than medically necessary
- Penalize providers for assisting members in filing appeals or grievances
- Prohibit providers from discussing treatment options with members
- Restrict providers from discussing lower-cost treatment alternatives with members

Provider Information Requirements

Providers must maintain accurate information on file with UNMH and CCP at all times, including:

- National Provider Identifier (NPI) individual and group
- Tax Identification Number (TIN)
- Physical and mailing/billing addresses
- Phone, fax, and email contact information
- Specialty and board certification status
- Hospital affiliations
- Panel status (accepting or not accepting new patients)
- Hours of operation

Submitting Changes to Provider Information

Notify UNMH of any changes to provider information at least 30–60 days prior to the effective date of the change. For Tax ID changes, contact your Provider Relations Representative directly and submit a new W-9.

Providers should submit any demographic changes to UNM Health Insurance Plan at Providers_UNMHealthInsPlan@salud.unm.edu.

Submitting Changes to Provider Information

Participating providers are responsible for promptly notifying UNMH and CCP of changes to their provider, practice, or organizational information. Timely updates help maintain accurate provider directories, support eligibility and network verification, and prevent delays or denials in claims processing and payment.

Report changes as soon as possible and before the effective date whenever advance notice can be provided. Updates may include:

Provider or practice name, address, telephone number, or contact information

Billing, mailing, or service location changes

Tax identification number, National Provider Identifier, or billing entity changes

Addition or removal of practitioners, facilities, specialties, or service locations

Ownership, affiliation, or organizational changes

Licensure, certification, accreditation, or professional liability insurance changes

Provider panel status, including whether the provider is accepting new patients

Electronic funds transfer, remittance, or claims-submission information

Practice closure, relocation, retirement, leave of absence, or termination of participation

Requests must be submitted through UNMH's provider-maintenance process and include all required forms and supporting documentation. Submission of a change does not guarantee immediate approval or system update. Providers should retain confirmation of submission and verify that the change has been completed before submitting claims under new information or representing a new location or practitioner as participating.

Failure to report changes timely may result in inaccurate directory information, claim payment delays, misdirected communications, recovery of overpayments, or processing of services as out-of-network. Changes affecting a provider's contract, credentialing status, ownership, tax identification number, or network participation may require additional review, credentialing, or execution of a new agreement.

Provider Education and Training

CCP offers educational resources through the Provider Academy, including:

- Provider Training resources
- Webinars on claims, authorizations, quality improvement, and care coordination
- A comprehensive resource library available on the CCP/UNMHIP provider website

  CCP Provider Academy

5 | PROVIDER ROLES, RIGHTS & RESPONSIBILITIES

All UNMHIP Provider Responsibilities

All providers participating in the UNMHIP network are expected to:

- Verify member eligibility prior to providing non-emergency services
- Provide medically necessary covered services in accordance with the member's benefit plan
- Submit claims accurately and in a timely manner
- Follow referral and prior authorization procedures as described in this manual
- Maintain confidentiality of all member records in compliance with HIPAA
- Maintain medical records for members in accordance with state and federal requirements
- Comply with UNMHIP's Utilization Management (UM) requirements
- Collect only applicable member cost-sharing amounts (copays, deductibles, coinsurance) balance billing is prohibited for covered services
- Notify CCP of any sanctions, restrictions, or limitations on licensure within 30 days of occurrence
- Comply with member rights and non-discrimination requirements
- Participate in CCP audits and data validation requests

Primary Care Providers (PCPs)

Types of PCPs

A Primary Care Provider (PCP) may be a General Practitioner, Family Medicine Physician, Internal Medicine Physician, OB-GYN, Geriatrician, Pediatrician, Certified Nurse Practitioner (CNP), or Physician Assistant (PA) who meets UNMHIP network credentialing requirements. In unique circumstances, UNMHIP may authorize a specialist to act as a PCP on behalf of a member at the request of the provider.

PCP Responsibilities

- Serve as the member's primary point of contact for coordinating healthcare services
- Provide timely access to appropriate care and services covered under UNMHIP
- Ensure continuity of care and appropriate referrals to in-network specialists
- Maintain 24/7 availability or on-call coverage arrangements
- Conduct and document preventive health screenings appropriate for the member's age and sex

Access Standards — PCPs

Visit Type	Appointment Availability Standard
Urgent Care (not emergency)	Within 24 hours of notification; 7 days a week, 24-hour access to triage (PCP triage can be via telephone)
Routine, Symptomatic	No greater than fourteen (14) calendar days, unless member requests later date

Visit Type	Appointment Availability Standard
Routine, Asymptomatic	No greater than thirty (30) calendar days, unless member requests a later date
Preventive / Wellness	No greater than thirty (30) calendar days unless member requests later date
After-Hours Coverage	24/7 availability required answering service or on-call provider

Specialist Responsibilities

- Accept referrals from UNMHIP PCPs and other in-network providers
- Communicate findings and treatment plans back to the referring PCP in a timely manner
- Obtain prior authorization for specialty services that require it
- Ensure in-network referrals for ancillary services

Access Standards — Specialists

Visit Type	Appointment Availability Standard
Urgent Specialty Care	Consistent with clinical urgency, but no more than 24 hours.
Routine Specialty, Symptomatic	Consistent with clinical urgency, but no more than twenty-one (21) calendar days.

Specialist Responsibilities Related to Appointment Availability

Participating specialists are responsible for maintaining appointment availability that supports timely access to medically necessary care. Appointment scheduling should reflect the member's clinical condition and urgency, with routine specialty consultations available within **21 calendar days**, and urgent specialty appointments within **24 hours**, unless the member requests a later date.

Specialists should maintain sufficient appointment capacity, provide timely follow-up visits based on the member's clinical needs, and promptly communicate scheduling barriers that may affect continuity of care. Members with scheduled appointments should generally be seen within **30 minutes** of the appointment time. When an emergency or other urgent circumstance causes a delay, the member should be offered an appointment with another available provider or rescheduled within **two (2) business days**.

Specialists must maintain accurate office hours, location, panel status, and appointment availability information and cooperate with appointment-access surveys, audits, and other monitoring activities conducted by UNMHIP or CCP.

Responsibilities of Network Hospitals and Facilities

- Notify CCP within 2 business days of an inpatient admission
- Obtain prior authorization for non-emergency inpatient admissions
- Coordinate discharge planning with CCP case management
- Provide emergency services without prior authorization to any UNMHIP member

Telemedicine

UNMHIP supports the use of telemedicine for appropriate clinical services. Telemedicine services must comply with applicable state licensure laws and CCP telemedicine policies.

UNMHIP supports the delivery of eligible health care services through telemedicine when clinically appropriate. Telemedicine may be used to provide diagnosis, consultation, treatment, and follow-up care for certain nonemergency medical, behavioral health, and substance use disorder conditions without requiring a traditional in-person visit. Services may be delivered through real-time audio and video or other approved telecommunications technology, as permitted by applicable law and Plan requirements.

Telemedicine services must be provided by an appropriately licensed and credentialed provider acting within the scope of their professional license. Participating providers are responsible for:

Verifying the member's eligibility and telemedicine benefits before providing services;

Determining whether telemedicine is clinically appropriate for the member's condition;

Meeting the same professional, clinical, privacy, security, documentation, and continuity-of-care standards that apply to in-person services;

Obtaining any required consent and prior authorization;

Referring the member for in-person, urgent, or emergency care when the member's condition cannot be appropriately managed remotely; and

Submitting claims using the applicable procedure codes, modifiers, place-of-service codes, and other billing information required by CCP.

Coverage and member cost-sharing may vary based on the service, provider type, delivery method, network status, and applicable benefit plan. Providers should verify benefits and authorization requirements before each telemedicine encounter. The availability of telemedicine does not guarantee coverage or payment.

Medical Records

Medical Record Standards

Provider medical records must be:

- Legible, complete, and organized
- Dated and signed by the treating provider
- Available to CCP for auditing

Transfer of Medical Records

When a member transitions to a new provider, medical records must be transferred in a timely manner upon receipt of a valid authorization. Reasonable copying fees may apply per applicable state law.

Cultural Competency

Providers must offer services in a manner that is sensitive to the cultural, linguistic, and social needs of UNMHIP members. CCP provides cultural competency training and resources through the Provider Academy.

Providers must ensure that qualified language assistance is available to individuals with limited English proficiency and that appropriate communication support is provided to patients covered by the Americans with Disabilities Act. Providers are responsible for selecting and coordinating interpreter services through a vendor of their choice.

6 | CREDENTIALING & RECREDENTIALING

Credentialing Contact Information

Credentialing Department	UNM Health Insurance Plan
Phone	505-272-4000
Email	Providers_UNMHealthInsPlan@salud.unm.edu
Mailing Address	933 Bradbury Ave SE Albuquerque, NM 87106

Overview

UNMH credentials individual and organizational providers participating in the UNMHIP network. The credentialing process verifies appropriate training, experience, licensure, and competence to ensure that all providers are qualified to render quality care to UNMHIP members.

Eligibility and Standards

Practitioner Credentialing Requirements

- Current, valid, unrestricted license to practice in the applicable state(s)
- Current DEA certificate (where applicable)
- Board certification or board eligibility (specialty-dependent)
- Malpractice insurance meeting UNMH minimum requirements
- Clean sanctions history no active exclusions from federal or state programs
- Completed CAQH ProView application (primary source verification)

Practitioner Credentialing Requirements

Practitioners must successfully complete the credentialing process before participating in the UNM Health Employee Medical Plan network, unless provisional participation has been expressly approved. Credentialing includes verification of the practitioner's education, training, licensure, professional qualifications, board-certification status where applicable, hospital privileges, professional liability coverage, and relevant disciplinary, legal, licensing, or medical-legal history.

Practitioners must submit a complete and accurate credentialing application, supporting documentation, required attestations, and authorization for primary-source verification through the TPA's designated credentialing process. Practitioners are responsible for maintaining current information in CAQH and promptly reporting changes that may affect their qualifications or participation status.

Credentialing approval does not, by itself, establish network participation. A practitioner may provide services as an in-network provider only after credentialing and contracting requirements have been completed and the practitioner has received written confirmation of participation and an effective date. Participating practitioners must continue to meet credentialing standards and cooperate with periodic recredentialing, verification, audit, and information requests.

Facility and Organizational Provider Requirements

- Current state license or certification for the applicable facility type
- Applicable accreditation (e.g., Joint Commission, AAAHC, CARF)
- CMS Certification Number (CCN) where applicable
- Liability insurance meeting CCP minimum requirements

Credentialing Process

Providers interested in joining the UNMHIP network should reach out via email at Providers_UNMHealthInsPlan@salud.unm.edu for more information.

Recredentialing

UNMH conducts recredentialing of all participating providers at least every three (3) years, or sooner if triggered by an adverse event or quality concern. Providers must cooperate with recredentialing requests within the required timeframes.

Right to Review and Appeal

Providers have the right to review information submitted in support of their credentialing application, to correct erroneous information, and to appeal adverse credentialing determinations. Contact the UNMH Credentialing Department to initiate a review or appeal.

Ongoing Monitoring

UNMH conducts ongoing monitoring between credentialing cycles, including review of: OIG/SAM exclusion lists, state license status, malpractice claims activity, and member grievances involving provider conduct. Providers must report any of the following to UNMH within 30 days of occurrence:

- State or federal sanctions, restrictions, or limitations on licensure
- Loss or suspension of hospital privileges
- Criminal charges related to the delivery of healthcare services
- Changes in malpractice insurance coverage

7 | UTILIZATION MANAGEMENT

Overview

CCP's Utilization Management (UM) program is designed to promote fair, impartial, and consistent utilization decisions and care coordination for UNMHIP members. The UM program:

- Ensures confidentiality of member health information
- Make decisions based on clinical evidence, medical necessity, and benefit availability
- Objectively monitors delivery of high-quality, cost-effective services
- Comply with all applicable federal and state UM regulations

Non-Discrimination Policy

CCP does not make UM decisions based on a member's race, color, national origin, sex, age, disability, or other protected characteristics. UM criteria are applied consistently to all UNMHIP members regardless of demographic factors.

Clinical Practice Guidelines

UM decisions are guided by recognized clinical practice guidelines, including:

- Change Healthcare InterQual® Criteria
- American Society of Addiction Medicine (ASAM) criteria for substance use disorders
- CMS and State guidelines

Emergency Services

Emergency services are covered without prior authorization for any UNMHIP member presenting with an emergent medical condition. An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in:

1. Serious jeopardy to the individual's health (or the health of a pregnant individual or unborn child);
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or body part

Providers must notify CCP within 2 business days of an emergency inpatient admission. Post-service authorization and retrospective review will be conducted for emergency services according to established review timelines.

Services Requiring Prior Authorization

Prior authorization is required for certain services before they are rendered. Refer to the UNMHIP Prior Authorization List, available on the provider portal, for a complete and current list of services requiring authorization. CCPcares.org

Services Typically Requiring Prior Authorization include but are not limited to the following:

- All Inpatient Hospital Admissions/Observation Stays
- Invasive Diagnostic Procedures
- Dialysis
- Elective Surgery (Inpatient, Outpatient, Ambulatory Surgery)
- High-tech radiology (MRI, CT, PET scan, nuclear medicine)
- Specialty medications
- Out-of-network services
- Transplants and Related Care

Submitting Prior Authorization Requests

Providers must submit authorization requests through the CCP secure provider portal, PlanLink, at http://planlink.ccpcares.org/.

Timeliness of UM Decisions

Request Type	Decision Timeframe
Non-Urgent Pre-Service	10 business days of receiving request with all pertinent clinical information. If sufficient relevant clinical information is not available to make a determination, the Plan may request an extension of the decision-making timeframe for an additional ten (10) business days
Urgent/Expedited Pre-Service	3 business days of receipt of the request with all pertinent clinical information. If sufficient relevant clinical information is not available to make a determination, the Plan may request an extension of the decision-making timeframe for an additional three (3) business days
Concurrent Review (inpatient)	Initial determination is issued within 2 business days of receipt of the request with all pertinent clinical information. If sufficient relevant clinical information is not available to make a determination, the Plan may request an extension of the decision-making timeframe for an additional two (2) business days
Post-Service / Retrospective	Initial determination is issued within 30 calendar days of receipt of the request with all pertinent clinical information.

Medical Necessity

Coverage for services under UNMHIP requires that the services be medically necessary. Medical necessity means services or supplies that are:

- Appropriate and consistent with the diagnosis or treatment of the member's condition
- In accordance with generally accepted standards of medical practice
- Not solely for the convenience of the member, provider, or facility
- The most appropriate level of care that can safely be provided

Continuity of Care

Newly enrolled UNMHIP members who are under active treatment may continue care with their current provider for a transitional period, even if that provider is not yet in the UNMHIP network, when medically necessary, for no less than 60 days. The out of network provider must agree to continue provide services to the patient. The out of network provider may be required to complete a single-case agreement. Contact CCP Case Management at 866-602-1751 to request a continuity of care review.

8 | CLAIMS CODING & BILLING

Overview

Providers must submit claims in compliance with UNMHIP billing requirements and applicable federal and state regulations. Accurate and timely claim submission ensures prompt payment and reduces the risk of denials.

Required Provider Information

All claims must include the following provider information:

- Provider name (as listed on current W-9)
- National Provider Identifier (NPI) individual and group/organizational NPI
- Tax Identification Number (TIN)
- Physical location address of service
- Billing name and address

Electronic Claims Submission

CCP accepts electronic claims via Availity. Submit electronic claims using Payer ID:

EDI Claims Clearinghouse – Availity

Submitter ID# 59064

Phone: 1-800-282-4548

Claims Reconsideration Fax: 954-417-7187

Electronic claims must comply with HIPAA-compliant 837P (professional) and 837I (institutional/facility) transaction formats.

Timely Filing Requirements

Claim Type	Filing Deadline
Participating Providers (initial claim)	180 days from date of service
Plan as Secondary Payer	180 days from primary payer
Corrected Claims	Within 180 days of date of service
Claims Appeals / Reconsideration	Within 90 days from EOB date

Member Billing Restrictions

Providers may not balance bill UNMHIP members for covered services beyond the applicable cost-sharing amounts (copay, deductible, coinsurance). Providers may only bill members for:

- Applicable copays, deductibles, and coinsurance amounts specified in the member's benefit plan
- Non-covered services — only when the member has been notified in advance and provided written consent

Clean vs. Unclean Claims

A clean claim includes all required data elements and can be processed without additional information. An unclean claim is missing required information or contains errors requiring correction before processing. Rejected claims lack essential data; denied claims fail due to clinical, eligibility, or billing issues.

Common Reasons for Claim Denial

- Missing or incorrect NPI, TIN, or taxonomy code
- Member not eligible on date of service
- Service requires prior authorization — authorization not on file
- Claim submitted after timely filing deadline
- Duplicate claim submission
- Incorrect or unsupported diagnosis/procedure code combinations
- Coordination of benefits — primary payer information missing

Corrected Claims and Reconsideration

Submit corrected claims through the PlanLink provider portal or via paper with a corrected claim indicator. Include all supporting documentation. Providers will receive a revised Explanation of Payment (EOP) if the original decision is overturned.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

CCP provides EFT and ERA at no charge to participating providers. Enrolling in EFT ensures faster, more secure payment directly to your bank account. Sign up using the form found at: *CCPcares.org - EFT Form*

9 | PROVIDER PORTAL & ELECTRONIC TOOLS

PlanLink — Secure Provider Portal

CCP's secure provider portal, PlanLink, allows UNMHIP network providers and office staff to access a comprehensive set of administrative tools. Access PlanLink at: planlink.ccpcares.org

PlanLink Features

- Confirm member eligibility, benefits, and PCP assignment
- Submit prior authorization requests
- View authorization and claim status
- Submit electronic claim appeals and corrections
- Send secure messages to CCP
- Access explanation of payment (EOP) remittance information
- View and download provider training resources

Availity — Electronic Claims Submission

Providers use Availity to submit electronic claims to CCP. For Availity support: 1-800-AVAILITY (1-800-282-4548) or availity.com.

Guest Access

Non-registered users may access limited functions such as member eligibility and claim status through the guest access feature on the PlanLink portal.

CCP and UNMHIP Provider Website

Providers can access the following resources online:

- Provider Directory
- Provider Manual (this document — most current version)
- Prior Authorization Request Forms and Services Requiring Prior Authorization list
- Clinical Practice Guidelines
- Provider Training and Education (Provider Academy)
- Provider Newsletter
- Drug formulary / Pharmacy Benefit information CCPcares.org - For Providers

10 | BEHAVIORAL HEALTH SERVICES

Overview

UNMHIP covers a comprehensive range of behavioral health (mental health and substance use disorder) services for eligible members. CCP is committed to integrating medical and behavioral health care to support whole-person wellness. Teladoc is also available to provide behavioral health services.

Covered Behavioral Health Services

Covered behavioral health services may include, but are not limited to:

- Outpatient mental health therapy (individual, group, family)
- Outpatient substance use disorder (SUD) treatment
- Psychiatric evaluation and medication management
- Intensive Outpatient Programs (IOP)
- Partial Hospitalization Programs (PHP)
- Inpatient psychiatric care
- Inpatient detoxification
- Crisis stabilization services
- Applied Behavior Analysis (ABA) for applicable diagnoses

For additional details, including service descriptions, eligibility guidelines, and authorization requirements, please visit our website at https://ccpcares.org/for-providers/.

This resource provides comprehensive information to help members and providers better understand available behavioral health benefits and access pathways.

Prior Authorization — Behavioral Health

The following behavioral health services typically require prior authorization:

- Non-emergency inpatient psychiatric admissions
- Intensive Outpatient Programs (IOP)
- Partial Hospitalization Programs (PHP)
- Residential treatment (behavioral health or SUD)
- Applied Behavior Analysis (ABA) initial and continued authorization

Providers must submit authorization requests through the CCP secure provider portal, PlanLink, at planlink.ccpcares.org. For services requiring fax submission, use the fax number provided on the prior authorization request form [pending link].

24/7 Behavioral Health Crisis Line

For behavioral health crises, members and providers may contact:

The New Mexico Crisis & Access Line (NMCAL) at 1-855-NMCRISIS (1-855-662-7474). NMCAL is staffed by trained behavioral health professionals who can provide crisis intervention, assessments and referrals to local resources. NMCAL is a free and confidential service available to anyone in New Mexico.

If there is an immediate risk to life or safety, Members should seek immediate attention at the nearest emergency room or call 911.

Coordination of Physical and Behavioral Health

Providers are expected to coordinate care between physical health and behavioral health services. PCPs play a critical role in screening members for behavioral health conditions and facilitating appropriate referrals. Evidence-based screening tools recommended include:

- PHQ-9: Depression screening (adults)
- PHQ-A: Depression screening (adolescents)
- CAGE or AUDIT: Alcohol use screening
- CRAFFT: Adolescent substance use screening
- SBIRT: Screening, Brief Intervention, and Referral to Treatment

11 | PHARMACY PROGRAM

Pharmacy Benefit

UNMHIP provides a pharmacy benefit that covers medically necessary prescription drugs on the UNMHIP Preferred Drug List (PDL). The pharmacy benefit is administered through:

Prime Therapeutics

Member Services: 833-559-5676

Pharmacy Help Desk: 833-716-2523

Express Scripts Home Delivery: 833-247-8963

Accredo Specialty Pharmacy: 833-275-4894

Formulary and Medication Management

Formulary & Prescription Resources

Starting January 1, 2027, members can visit PrimeOne.com/Member to:

- **Review the Preferred Drug List (Formulary)** for covered prescription medications and any applicable coverage requirements
- **Find In-Network Pharmacies** in their area and **understand prescription costs**
- Access pharmacy benefit resources

Specialty Pharmacy

Accredo Specialty Pharmacy provides certain specialty medications to UNM Health Insurance Plan members. Learn about specialty medication support, home delivery services, refill options, and how to get started with Accredo.

Mail Order Pharmacy Services

90DayMyWay is a program offered through the pharmacy benefits. It gives members a 90-day supply of long-term medicines. Learn more about 90DayMyWay at PrimeOne.com/Member.

Preferred Drug List (PDL)

The PDL is a formulary that lists covered prescription medications by tier. The PDL identifies preferred medications and may include coverage requirements such as prior authorization, step therapy, and quantity limits. The PDL is updated periodically. Providers should check the current PDL before prescribing.

PrimeOne.com/Member

Prior Authorization — Pharmacy

Certain medications require prior authorization before dispensing. When PA is required, the prescribing provider must submit the necessary clinical information, including relevant diagnosis, treatment history, and supporting documentation, for review.

Providers may access PA criteria, request forms, and electronic submission resources through PrimeOne.com/Member.

Prior authorization approval is subject to applicable plan benefits, limitations, and exclusions and does not guarantee payment.

Step Therapy

Step Therapy is a pharmacy utilization management program that may require members to try one or more clinically appropriate, preferred medications before coverage is considered for certain alternative medications.

Administered by Prime Therapeutics, step therapy requirements are intended to encourage the use of safe, effective, and cost-efficient treatment options while supporting appropriate prescribing practices.

When a prescribed medication is subject to step therapy, providers should review the applicable criteria to determine whether prerequisite medications have been tried or whether a clinical exception may be appropriate. Supporting documentation may be required to establish medical necessity when requesting coverage outside the standard step therapy requirements. Members are responsible for the applicable copayment associated with the covered brand-name drug.

Specialty Medications

Specialty medications are generally prescribed to treat complex, chronic, or rare medical conditions and may require specialized handling, administration, monitoring, or patient support. Providers should verify applicable coverage requirements and pharmacy dispensing arrangements prior to prescribing specialty medications. Specialty drug coverage may vary depending on whether the medication is administered under the member's medical or pharmacy benefit. Specialty medications require prior authorization and may be subject to restricted dispensing through a specialty pharmacy network. Contact the Prime Therapeutics for details.

Drug Exclusions

Drug exclusions may be based on formulary design, clinical considerations, availability of therapeutic alternatives, or other plan-specific coverage limitations. Medications excluded from coverage are generally the financial responsibility of the member unless an applicable exception is approved.

Providers should review the current formulary and applicable plan documents to identify excluded medications and available covered alternatives. When clinically appropriate, providers may request a coverage exception in accordance with established pharmacy benefit procedures. Contact Prime Therapeutics for additional information regarding drug exclusions and coverage exception requirements.

12 | QUALITY IMPROVEMENT

Patient Safety

Providers must report adverse incidents or serious adverse events to CCP as required by applicable law and contractual obligations. Contact your Provider Relations Representative for adverse event reporting guidance.

Fraud, Waste, and Abuse (FWA)

CCP has a robust Fraud, Waste, and Abuse (FWA) prevention program. Providers must comply with all applicable federal and state FWA laws and regulations, including:

- False Claims Act (31 U.S.C. §§ 3729–3733)
- Anti-Kickback Statute
- Stark Law (Physician Self-Referral Law)
- HIPAA fraud and abuse provisions

To report suspected fraud, waste, or abuse, contact the CCP FWA Hotline:

FWA Hotline: 855-843-1106

Alternatively, they may contact the compliance officer by phone, 954-622-3482 or email, ccp.compliance@ccpcares.org.

Reports may be made anonymously. Retaliation against individuals who report suspected FWA in good faith is strictly prohibited.

13 | MEMBER RIGHTS & RESPONSIBILITIES

Member Rights

UNMHIP members have the right to:

- Receive information about the health plan, available services, and how to access them
- Be treated with respect and dignity without discrimination
- Receive care that is free from discrimination based on race, color, national origin, age, disability, or sex
- Participate in decisions about their healthcare, including the right to refuse treatment
- Have their personal health information kept confidential in accordance with HIPAA and applicable state and federal laws
- File a complaint or grievance if they are dissatisfied with care or services
- Appeal coverage decisions they disagree with
- Receive a copy of their medical records
- Designate a representative to act on their behalf
- Receive information about participating providers and applicable requirements for accessing care
- Receive appropriate assistance with understanding health information and accessing services, consistent with applicable legal requirements

Member Responsibilities

UNMHIP members are responsible for:

- Providing accurate and complete information to their providers and to CCP
- Following the treatment plans agreed upon with their providers and disclosing any barriers that may effect care
- Using in-network providers whenever possible
- Obtaining required prior authorizations before receiving non-emergency services
- Paying applicable cost-sharing amounts (copays, deductibles, coinsurance) at time of service
- Notifying CCP and their PCP, if applicable, of emergency care received
- Communicate changes in health status to their provider(s)
- Always provide member identification and coverage information when seeking services.
- Keep scheduled appointments or provide timely notice when cancellation or rescheduling is necessary
- Treat providers and staff with courtesy and respect

Advance Directives

Providers must ask adult UNMHIP members whether they have an advance directive (such as a living will, healthcare proxy, or durable power of attorney for healthcare) and document the response in the medical record. A copy of the advance directive should be placed in the member's medical record upon request.

Member Complaints, Grievances, and Appeals

Definitions

Complaint	An expression of dissatisfaction about any aspect of plan operations, including customer service or the quality of care received.
Grievance	A formal process for a member to express dissatisfaction with care, services, or plan policies.
Appeal	A request by a member (or provider on the member's behalf) to review a denial, limitation, or termination of a covered service.

How to File a Grievance or Appeal

Members may file a grievance or appeal by:

- Calling Member Experience at 866-602-1751
- Submitting a written grievance or appeal to:

  Community Care Plan

  Attention: Grievance & Appeal Coordinator

  1643 Harrison Parkway, Building H, Suite 200

  Sunrise, Florida 33323

  Email grievancesandappeals@ccpcares.org

  Fax 954-251-4848

Complaints may initially be addressed informally through Customer Service by telephone, mail, or email. When the matter is not resolved, the member may request an internal review. The review request must be submitted within 180 days after the member receives notice of the decision, unless circumstances beyond the member's control prevented timely filing. Members may not be retaliated against for submitting a complaint or appeal.

Provider Assistance

Providers may assist members in filing grievances and appeals. Providers may also file a claim dispute or provider appeal on behalf of a member with appropriate authorization. For claim disputes, refer to Section 8 of this manual.

14 | PROVIDER CLAIMS APPEALS & DISPUTES

Provider Complaints and Disputes

UNMHIP providers who have questions or disputes regarding claims payment, coverage determinations, or other administrative matters should contact CCP Provider Operations.

Claims Disputes and Reconsideration

Providers may request reconsideration of a denied or underpaid claim by:

- Submitting a claim reconsideration request through PlanLink within the filing deadline
- Including supporting documentation when applicable (medical records, invoices, operative notes as applicable)

Claims appeals must be submitted within 90 days after the Remittance Advice. Submit appeals along with the Claim Reconsideration Form. CCPcares.org - Provider Forms

15 | FRAUD, WASTE & ABUSE

Overview

CCP and UNMHIP are committed to maintaining the integrity of the healthcare program and protecting plan assets from fraud, waste, and abuse (FWA). Providers are expected to actively support FWA prevention efforts.

Definitions

Fraud	Intentional deception or misrepresentation to obtain unauthorized benefits — e.g., billing for services not rendered, upcoding, unbundling.
Waste	Overutilization or misuse of plan resources without intentional deception — e.g., ordering unnecessary tests.
Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices — e.g., billing for services that are not medically necessary.

Provider FWA Responsibilities

UNMHIP providers must:

- Maintain accurate and complete medical records to support billed services
- Submit claims only for services that were actually rendered and medically necessary
- Use correct procedure and diagnosis codes that accurately reflect services rendered
- Refund overpayments promptly upon identification
- Implement internal controls to detect and prevent FWA
- Cooperate with CCP and regulatory audits
- Not employ or contract with individuals or entities excluded from federal healthcare programs (check OIG/SAM Exclusion List)

Reporting Suspected FWA

To report suspected fraud, waste, or abuse involving UNMHIP, contact:

Suspected instances of Fraud, Waste and Abuse can be reported directly to the Community Care Plan Compliance Officer at 954-622-3482 or via email at CCP.Compliance@ccpcares.org or CCP.SIU@ccpcares.org. Anonymous reports can be made to CCP by calling 855-843-1106 or going to www.lighthouse-services.com/ccpcares. Reports may be made anonymously. CCP prohibits retaliation against anyone who reports suspected FWA in good faith.

False Claims Act

Providers who knowingly submit false claims to a federally funded benefit plan may be subject to civil and criminal penalties under the False Claims Act, including fines of up to three times the amount of the false claim plus additional per-claim penalties.

16 | GLOSSARY OF TERMS

The following terms and acronyms are used throughout this Provider Reference Manual. Providers are encouraged to familiarize themselves with these definitions.

Term / Acronym	Definition
ABA	Applied Behavior Analysis — a therapy based on the science of behavior and learning.
CCP	Community Care Plan — the health plan and plan administrator for UNMHIP.
COB	Coordination of Benefits — process for determining payment responsibility when a member has more than one health plan.
EFT	Electronic Funds Transfer — direct deposit of claim payments to a provider's bank account.
EOP	Explanation of Payment — the document CCP sends to providers explaining how a claim was processed.
ERA	Electronic Remittance Advice — electronic version of the EOP.
FWA	Fraud, Waste, and Abuse.
HIPAA	Health Insurance Portability and Accountability Act — federal law governing the privacy and security of health information.
IOP	Intensive Outpatient Program — a structured behavioral health treatment program.
MTM	Medication Therapy Management — pharmacy services to optimize medication use.
NCQA	National Committee for Quality Assurance — accreditation organization for health plans.
NPI	National Provider Identifier — a unique 10-digit identification number for healthcare providers.
OIG	Office of Inspector General (U.S. Department of Health & Human Services).

Term / Acronym	Definition
PBM	Pharmacy Benefit Manager — the company that administers the pharmacy benefit on behalf of UNMHIP.
PCP	Primary Care Provider — the provider responsible for coordinating a member's overall care.
PDL	Preferred Drug List — the UNMHIP formulary of covered medications.
PHP	Partial Hospitalization Program — a structured day-treatment behavioral health program.
SUD	Substance Use Disorder.
TIN	Tax Identification Number — used by CCP for claims payment and IRS reporting.
UM	Utilization Management — the process of reviewing the appropriateness of services and care.
UNMH	University of New Mexico Hospitals — the plan sponsor of UNMHIP.
UNMHIP	UNM Health Insurance Plan — the employee health plan described in this manual.

APPENDIX | APPENDICES

Appendix A — Prior Authorization Forms

CCPcares.org - For Providers

Appendix B — Services Requiring Prior Authorization

CCPcares.org - For Providers

Appendix C — UNMHIP Benefit Summary

CCPcares.org - For Providers

Appendix D — Preferred Drug List (PDL)

CCPcares.org - For Providers

Appendix E — CCP Provider Resources

Additional CCP resources for UNMHIP providers:

- CCP Provider Website: www.ccpcares.org/providers
- PlanLink Provider Portal: planlink.ccpcares.org
- Provider Academy (Training): https://ccpcares.org/for-providers/provider-tools/provider-academy/