New Mexico Regulatory Appendix

This New Mexico Regulatory Requirements Appendix (the "Appendix") is made part of this Agreement entered into between United Behavioral Health ("UBH") and the health care professional named in this Agreement ("Provider").

This Appendix applies to all products or Benefit Plans sponsored, issued or administered by or accessed through UBH to the extent such products are regulated under New Mexico laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

UBH and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix, and be read in accordance with applicable laws and regulations.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "UBH" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix shall be defined as set forth in the Agreement.

1. **Member Hold Harmless.** Provider agrees that in no event, including but not limited to nonpayment by UBH or Payor, as applicable, insolvency of UBH or Payor, or breach by UBH of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member or person acting on behalf of the Member, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting coinsurance, deductibles or copayments as specifically provided in the Member's Benefit Plan, or fees for uncovered health care services delivered on a fee-for-service basis to Member, nor from any recourse against UBH or its successor, or Payor, as applicable.

   This Member Hold Harmless provision shall survive the termination of this Agreement regardless of the reason for termination, including the insolvency of UBH.

2. **Assignment.** Provider shall not assign or delegate any rights and responsibilities under this Agreement without the prior written consent of UBH.

3. **Malpractice Insurance.** Provider shall maintain adequate professional liability and malpractice insurance in at least the amount specified in the Agreement. Provider shall notify UBH not more
than ten (10) days after Provider's receipt of notice of any reduction or cancellation of such coverage.

4. **Rights of Members.** Provider shall observe, protect, and promote the rights of Members as patients.

5. **Discrimination Prohibited.** Provider shall provide Covered Services without discrimination on the basis of a Member's participation in the health care plan, age, gender, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement does not apply or shall not apply to circumstances when Provider appropriately does not render services due to limitations arising from Provider's lack of training, experience, or skill, or due to licensing restrictions. UBH will provide interpreters for limited English proficient (LEP) individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Such interpretive services will be made available to Provider's office at no cost to the Provider.

6. **Terms Consistent with New Mexico Statutes and Regulations.** The terms used in this Agreement and that are defined by New Mexico statutes and department regulations are used in this Agreement in a manner consistent with any definitions contained in said laws or regulations.

7. **Prohibited Provisions.** Nothing in this Agreement shall be construed to offer an inducement, financial or otherwise, to provide less than medically necessary services to a Member. In addition, nothing shall be construed to penalize Provider to assist a Member to seek a reconsideration of UBH's decision to deny or limit benefits to a Member. Nothing in this Agreement shall be construed to prohibit Provider from discussing treatment options with Members irrespective of UBH's position on treatment options, or from advocating on behalf of a Member or Members within the care coordination/utilization review or grievance process established by UBH or a person contracting with UBH. Nothing in this Agreement shall prohibit Provider from using disparaging language or making disparaging comments when referring to UBH.

8. **Payment of Clean Claims.** Pursuant to NMSA 59A-16-21.1, UBH or Payor, as applicable, shall pay Provider for Covered Services forty-five (45) days after a clean claim that UBH receives manually or thirty (30) days after a clean claim that UBH receives electronically. In instances where payment is not made within the above time frames, UBH or Payor shall be liable for the amount due and unpaid with interest in the amount of one and one-half percent a month as required by New Mexico law. For purposes of this section, clean claim means a manually or electronically submitted claim that: (a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of UBH's system and contains no deficiency; (b) is not materially deficient or improper, including lacking substantiating documentation currently required by UBH; and (c) has no particular or unusual circumstances requiring special treatment that

prevents payment from being made by UBH or Payor within thirty days of the date of receipt if submitted electronically or forty-five days if submitted manually.

9. Grievance System. UBH maintains procedures to provide for the presentation, management, and resolution of complaints and grievances brought by Members and Providers acting on behalf of a Member and within the Member's consent as required by New Mexico law. UBH will provide Provider and Members with written information regarding UBH's grievance processes and how UBH resolves grievances.

10. Continuation of Coverage after Termination. If this Agreement terminates without cause,

Members engaged in an ongoing course of treatment with Provider may continue to receive Covered Services from Provider for a time that is sufficient to permit coordinated transition planning consistent with the Member's condition and needs relating to continuity of care, and, in any event, shall not be less than thirty (30) days. If a Member has entered the third trimester of pregnancy at the time of termination of this Agreement, the transitional period shall include the provision of post-partum care directly related to the delivery.

For transitional periods exceeding thirty (30) days, UBH shall authorize continued care as provided in this section only if Provider agrees to accept reimbursement at the rates applicable prior to the start of the transitional period as payment in full; to adhere to UBH's quality assurance requirements and provide UBH all necessary medical information related to such care, and to otherwise adhere to UBH's Protocols, including but not limited to procedures regarding referrals, preauthorization and treatment planning approved by UBH.

UBH will not be required to permit a Member to continue treatment with Provider if this Agreement was terminated for reasons related to medical competence or professional behavior.

11. Availability and Confidentiality of Health Records. Provider agrees to make health records maintained by provider available to appropriate state and federal authorities and comply with all applicable state and federal laws and regulations regarding confidentiality of health records. This section shall include, but not be limited to, health records necessary to monitor and evaluate quality of care, conduct evaluations and audits, and to determine the necessity and appropriateness of health care services provided to Members.

12. Retroactive Adjustments for Overpayment of a Claim. Retroactive adjustments by UBH for overpayment of a claim must be made within 18 months absent Provider miscoding, claim submission error, suspected fraud and abuse; or retroactive adjustments required by other federal or state agencies.

13. Availability. All health care professionals and applicable health care facilities will provide, or arrange for the provision of, Covered Services 24 hours per day, seven days per week.

14. Utilization Management. Pursuant to NMAC 13.10.22.9 (D)(4), UBH will not retroactively deny reimbursement for a Covered Service provided to a Member by Provider when Provider relied upon the verbal or written authorization of UBH or its agents prior to providing the service to the Member, except in those cases where there was material misrepresentation or fraud.

15. **Review by Superintendent.** Pursuant to NMAC 13.10.16.10, a provider that is dissatisfied with the results of UBH's internal grievance procedure and that has exhausted UBH's internal grievance procedure may file a complaint with the superintendent regarding the subject of the provider's grievance to UBH. A provider seeking the superintendent's review of UBH's grievance decision shall file a written request with the superintendent within 30 days from receipt of a written decision of UBH concerning the grievance. After appropriate investigation of a provider's complaint, the superintendent may schedule and conduct a hearing pursuant to Article 4 of the Insurance Code.