20223

Health Care Provider Fee Schedule

&

Billing Instructions

STATE OF NEW MEXICO

Workers' Compensation Administration

ONE TEAM | ONE GOAL

A Better New Mexico for Workers and Employers

Effective January 1, 20223

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DEFINITIONS

For the purposes of this document, the following definitions apply to the provision of all services:

A. "ASA Relative Value Guide®" means a document published by the American Society of Anesthesiologists (ASA) which includes only CPT descriptive terms, identifying codes and modifiers for reporting medical services and procedures that relate to the practice of anesthesiology. The current calendar year edition of the ASA *Relative Value Guide*® applies.

B. "Assistant Surgeon" means a physician who actively provides assistance to the primary surgeon and is billed using modifier "80", "81" or "82". Modifier "81" means an assistant who does not participate in the entire procedure but provides minimal assistance to the primary surgeon. Modifier "82" means an assistant who provides surgery when a qualified resident surgeon is not available and is used primarily in teaching hospitals to indicate that a qualified resident surgeon is unavailable. Modifier "AS" is used to indicate that a Physician Assistant, Nurse Practitioner, or Certified Nurse Specialist serves as the assistant during surgery.

C. "Authorized Health Care Provider (HCP)" means the Health Care Provider selected in accordance with the Workers' Compensation Act.

D. "Average Wholesale Price (AWP)" means the average national price paid by pharmacies for pharmaceutical products, as determined and published at least monthly by any nationally recognized pricing guide.

E. "By-report (BR)" means a maximum amount for a service has not been established in the HCP Fee Schedule.

F. "Centers for Medicare & Medicaid Services (CMS)" means part of the Federal Department of Health and Human Services which administers programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Health Insurance Marketplace.

G. "Co-Surgeon" means two or more surgeons with different specialties work during the same operative session for the same beneficiary and the same date of service. All providers must use the co-surgeon Modifier "62". Modifier "62" shall only be used when the co-surgeons are of different specialties and are working simultaneously.

H. "Failed appointment" means an appointment with an HCP or caregiver for which the patient fails to show or arrives too late to be treated on the same day.

I. "Forms" means a bill for services that is rendered by an HCP, caregiver, or supplier submitted on one of the following forms as outlined in this document: (1) CMS-1500 (02/12); (2) UB-04 CMS-1450 (OMB No. 0938-0997).

J. "HCP Fee Schedule" means this *Health Care Provider Fee Schedule & Billing Instructions* document and is used for ease of reference.

K. "HCPCS" means Healthcare Common Procedure Coding System, a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).

L. "Implants, hardware and instrumentation" means surgical implants that are defined as any single-use item that is surgically inserted, deemed to be medically necessary and approved by the payer. The physician does not specify these items to be removed in less than six (6) weeks. This includes bone, cartilage, tendon or other anatomical material obtained from a source other than the patient; plates, screws, pins, cages; internal fixators; joint replacements; anchors; permanent neuro-stimulators; pain pump; and disposable instrumentation which includes ports, single-use temporary pain pumps, external fixators and temporary neuro-stimulators and other single-use items intended to be removed from the body in less than six (6) weeks.

M. "International Classification of Diseases (ICD-10-CM)" means a set of numerical diagnostic codes, 10th revision that is commonly referred to as ICD-10.

N. "Materials Supplied by an HCP (CPT Code 99070)" means supplies and materials over and above those usually included with the HCP or caregiver services and which are not governed by the DME section in this document. Examples include sterile trays, unit doses of drugs, bandages, elastic wraps, initial casting, splinting and strapping materials, removable splints and slings.

O. "Maximum Allowable Payment (MAP)" means the maximum amount reimbursed according to the HCP Fee Schedule for any outpatient services, not including emergency department visits, outpatient surgery visits or New Mexico Gross Receipts Tax.

P. "National Drug Code (NDC)" means a unique 10- or 11-digit, 3-segment number, which is a universal product identifier for over the counter and prescription drugs in the United States.

Q. "New hospital" means a hospital, as defined in NMSA 1978, Section 52-4-1, which has not completed its first fiscal year.

R. "New Mexico Gross Receipts Tax (NMGRT)" means the gross receipts tax or compensating tax as defined in Chapter 7, Article 9 of the New Mexico Statutes Annotated 1978 (the "Gross Receipts and Compensating Tax Act Regulations"). This tax is collected by the New Mexico Taxation and Revenue Department.

S. "New patient" means a patient who is new to the HCP, group practice or caregiver whose medical and administrative records need to be established. A patient shall also be considered a new patient if seen for a new injury or disability or when a lapse of three (3) or more years from the most recent prior visit has occurred.

T. "Official Disability Guidelines (ODG)" means Official Disability Guidelines by MCG Health, formerly registered trademarks of the Work Loss Data Institute (WLDI). WLDI was acquired by MCG Health, part of the Hearst Health network, in 2017".

U. "Payer" means an insurance carrier, certified self-insurer, or a third- party administrator (TPA) making workers' compensation medical, indemnity and/or other claims payments on behalf of an employer.

V. "Pharmacy Maximum Allowable Payment (Pharm MAP)" is based upon the maximum payment, that a pharmacy or authorized HCP is allowed to receive for any prescription drug, not including NMGRT.

W. "Practitioner" means any HCP, pharmacy, supplier, caregiver and/or Freestanding Ambulatory Surgical Center -- individually or in combination -- as appropriate to the context of the paragraph in which it is used.

X. "Referral" means the sending of a patient by the authorized HCP to another provider for evaluation or treatment of the patient. It is considered a continuation of the care provided by the authorized HCP.

Y. "Service component modifiers" means the designation of radiology and pathology or laboratory procedures that are divided into professional and technical components for billing purposes.

Z. "Services" means health care services, the scheduling of the date and time of the provision of those services, procedures, drugs, products or items provided to a worker by an HCP, pharmacy, supplier, caregiver, or Freestanding Ambulatory Surgical Center which are reasonable and necessary for the evaluation and treatment of a worker with an injury or occupational disease covered under the New Mexico Workers' Compensation Act or the New Mexico Occupational Disease Disablement Law.

AA. "Telemedicine services" means a two-way, real time interactive communication between the injured worker and the provider at a distant site. At a minimum, telemedicine includes audio and video telecommunications equipment.

BB. "Telephonic services" means non-face to face services provided to a patient using the telephone. Such services can include medical discussions, between a physician or other healthcare professional and a patient, that do not require direct, in person contact.

CC. "Usual and Customary Fee" means the monetary fee that an HCP normally charges for any given health care service. It shall be presumed that the charge billed by the HCP is that HCP's usual and customary charge for that service unless it exceeds the HCP's charges to self-paying patients or non-governmental third-party payers for the same services and procedures.

DD. "Worker" means an injured or disabled employee.

BILLING INSTRUCTIONS

For services that are billed on Form CMS-1500, “WORKERS' COMPENSATION" or "WORK COMP" must be printed or stamped at the top of each billing form. If a subsequent billing (or a copy of the original bill) is sent for the same service(s), it must be labeled “TRACER” or “TRACER BILL.”

The following forms, as adopted from CMS, are used to file New Mexico workers’ compensation claims and must include patient identification and appropriate information. For each procedure billed, the appropriate CPT code and descriptor must be included, regardless of which form is used.

1) CMS-1500 (02/12)
2) CMS-1450/UB-04

FASCs are to bill for services using Form CMS-1500. In addition to FASCs, Form CMS-1500 is also used for all HCP professional fees whose reimbursement is calculated according to the HCP Fee Schedule.

Pharmaceutical billings do not require a specific form.

Instructions for Completing Forms

Do not submit, email, fax, or mail completed 1500/1450 claim forms to the New Mexico Workers’ Compensation Administration. The ~~NM~~WCA does not process claims. Claim forms must be sent to the appropriate payer.

Form CMS-1500 (02/12)

Instructions for completing Form CMS-1500 are published by the National Uniform Claim Committee (NUCC)~~,~~ and may be found ~~using the following link:~~by referring to the NUCC website.

~~**http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2019_07_v7.pdf**~~

Form CMS-1450/UB-04

Instructions for Form CMS-1450/UB-04 may be found ~~using the following links:~~by referring to the National Uniform Billing Committee (NUBC) and CMS websites.

~~**https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1450**~~

~~**https://www.nubc.org/**~~

HCP FEE SCHEDULE

Anesthesia

The maximum allowable payment for the CPT code series 00100-01999 (which is specific to the field of anesthesia), shall be determined by including a monetary conversion factor of $ 62.54.

Monetary Conversion Factor		**Base Unit Value**		**Maximum Allowable Payment**
$ 62.54 per unit	x	Base Value + Time Units + Modifier	=	

The "base unit value" assigned to each procedure in the CPT code series 00100-01999 in the most current edition of the American Society of Anesthesiologists (ASA) Relative Value Guide® which has been adopted in the annual WCA Director's Fee Schedule Order shall be used when billing for anesthesia services.

"Time units" shall be billed in minutes. Anesthesia services shall be reimbursed based on one unit equal to 15 minutes and shall be determined by dividing the total number of minutes by 15 and rounding to the nearest hundredth. In other words, a 2 hour and 13-minute service shall be converted to 133 minutes; divide the total minutes (133) by 15 which equal 8.87 units. Anesthesia services provided during a hospital inpatient surgery or procedure shall be reimbursed by applying the appropriate hospital ratio.

Modifiers

Physical Status: The following six levels are consistent with the most current edition of the ASA Relative Value Guide's® ranking of patient physical status. Physical status modifiers should be included in billing, as appropriate, and shall adhere to the coding and unit value assignments in the ASA Relative Value Guide® as adopted in the annual WCA Director's Fee Schedule Order. Physical status modifiers are represented by the initial letter "P" followed by a single digit from 1 to 6 as defined below:

Modifier	Descriptor	Base Unit Value
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

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Qualifying Circumstances (more than one may be reported): This section lists important qualifying circumstances that can have a significant impact on the character of the anesthetic service provided. These modifying units may be added to the base unit values.

CPT Code	CPT Descriptor (list separately in addition to code for primary anesthesia procedure)	Base Unit Value
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70	1
99116	Anesthesia complicated by utilization of total body hypothermia	5

CPT Code	CPT Descriptor (list separately in addition to code for primary anesthesia procedure)	Base Unit Value
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions (specify) (an emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)	2

Under certain circumstances, medical service and procedures need to be further modified. For other modifiers that may be used for Anesthesia, please refer to *Appendix A – Modifiers* found in the AMA's *Current Procedural Terminology* as adopted in the annual WCA Director's Fee Schedule Order.

Anesthesia services billed on form UB-04 CMS-1450 shall be reimbursed by applying the appropriate hospital ratio.

COVID-19 Testing and Pathology

COVID-19 testing and pathology shall be billed using the appropriate CPT codes.

Durable Medical Equipment (DME)

DME purchases are reimbursed as follows:

Provider Invoice Cost	**X**	**1.25**	**+**	**Shipping & Handling and NMGRT**

All supplies and materials provided by an HCP shall be itemized.

Rental of DME shall not exceed 90 days unless it is determined by the payer to be more cost efficient to do so. Rental fees shall not exceed the cost of purchase as established in the formula above. Payers shall not be held liable for payment of rental fees billed above the cost of purchase.

Rental fees paid for the first 30 days of rent may be applied against the purchase price. Subsequent rental fees may not be applied against the purchase price. The decision to purchase should be made within the first 30 days of rental.

DME provided during a hospital inpatient stay shall be reimbursed by applying the appropriate hospital ratio.

Reasonable and necessary prosthetic/orthotic training or adjusting is excluded from the cost of the DME and may be billed separately.

The DME shall be pre-authorized by the payer within 72 hours after receipt of all supporting documentation, except when the worker is hospitalized, the authorization must be given within 24 hours. If a worker is hospitalized and the request is made when the payer's place of business is closed, such as on weekends and holidays, authorization shall be given by the close of business on the next business day. Authorization will be presumed if adjuster does not reply in the allotted timeframe. The HCP must include all invoices for DME when claims are submitted to the payer for processing.

Pre-authorization must be obtained by the HCP before services or equipment are provided or the payer will not be held liable for payment of the equipment provided.

Evaluation and Management (E/M) Services

New Mexico has a unique definition of "new patient" (see Definitions section.) The definition is also different from the one found in the AMA CPT guidelines.

All E/M services, including prolonged services, shall be billed using the appropriate AMA CPT guidelines adopted in the annual WCA Director's Fee Schedule Order.

~~You may refer to the following websites for these guidelines:~~

~~https://www.ama-assn.org/practice-management/cpt/implementing-cpt-evaluation-and-management-em-revisions~~

~~https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf~~

Explanation of Benefits (EOBs)

The following EOBs are grouped in accordance with the criteria for contesting health care services bills.

Standard EOBs

EOB-01	Claim not compensable. The compensability of this workers' compensation claim has been denied by the employer or payer.
EOB-02	Services are not reasonable and necessary. This service/procedure/item is not considered reasonable or necessary for the compensable problem.
EOB-03	Incomplete billing information or supporting documentation. The information/documentation listed was not included with the bill. The charge(s) will be evaluated upon its receipt. Forward expeditiously.

Inaccurate Billing/Billing Errors

EOB-04	According to the HCP Fee Schedule this procedure code is not a valid reimbursement code. Please resubmit with a valid code.
EOB-05	This procedure was billed more than once on the same date. (Indicate payment disposition.)
EOB-06	An identical bill for this claimant and date of service was previously submitted and paid, reduced, or denied.
EOB-07	The code for this service has been changed to agree with the CPT code for this procedure in the governing version of the HCP Fee Schedule.
EOB-08	The billed service is not substantiated by the medical notes.
EOB-09	This code is already included in procedure code number___, which was billed on (date). (Include the appropriate CPT code and the date billed.)
EOB-10	A new patient charge was made for this service without meeting the definition of "new patient" as found in the HCP Fee Schedule. Payment is commensurate with the established patient designation.

Specific EOB Reductions

EOB-11	This procedure/service was not provided by an authorized HCP as specified in NMSA 1978, Section 52-4-1.
EOB-12	Payment has been reduced commensurate with the level of service documented in the medical records (including procedures with surgical modifiers).
EOB-13	Payment has been prorated for this procedure.
EOB-14	Payment has been reduced to the HCP Fee Schedule, assigned hospital ratio, FASC amount, Pharm Maximum Allowable Payment (MAP) or the contracted or negotiated amount for this procedure or service.
EOB-15	This service was provided by a caregiver without an agreed upon fee.
EOB-16	Professional fee at 40% of the HCP Fee Schedule, technical fee at 60% of the HCP Fee Schedule, or billed amount, whichever is less.
EOB-17	Medical records shall accompany each bill at no charge.
EOB-18	Tax allowance reduced. Tax reimbursement has been processed according to the applicable tax rates in this jurisdiction on the date(s) of service(s).
EOB-19	Rental fee exceeds the cost of equipment purchase. Payment has been made as allowed under the HCP Fee Schedule and no further payment shall be made.
EOB-20	This charge was disallowed as additional information/definition is required to clarify service(s) rendered.
EOB-21	The required pre-authorization for this service/procedure was not obtained by the provider from the payer prior to scheduling or performing delivery of the service/procedure.
EOB-22	Upheld, no additional allowance has been recommended.

Facility Fees and Room Charges

Room charges billed by a hospital are reimbursed using the appropriate hospital ratio with the exception of in-hospital clinic facility charges (revenue code 51X), which are prohibited.

Failed Appointments

A failed appointment by an established patient may not be billed. Failed appointments may otherwise be reimbursed as provided in the table below.

Type of Failed Appointment	Description	Reimbursement
New Patient Appointment	A new patient fails to provide a two-business day notice of cancellation to the HCP	The missed appointment shall be reimbursed using CPT Code 99202 and annotated as "Failed Initial Appointment/New Patient".
New Patient Physical Therapy Appointment	A new patient fails to provide a two-business day notice of cancellation	The missed appointment shall be reimbursed at 60% of the HCP Fee Schedule.
Physical Impairment Rating (PIR) Assessment	A worker fails to provide a two-business day notice of cancellation of a PIR Assessment	The missed appointment shall be reimbursed at either 60% of the preapproved fee or 60% of the HCP's usual and customary fee if a fee was not preapproved.

Type of Failed Appointment	Description	Reimbursement
Mental Impairment Rating Assessment	A worker fails to provide a two-business day notice of cancellation of a Mental Impairment Rating Assessment	The missed appointment shall be reimbursed at either 60% of the preapproved fee or 60% of the HCP's usual and customary fee if a fee was not preapproved.
Functional Capacity Examination (FCE)	A worker fails to provide a two-business day notice of cancellation of an FCE	The missed appointment shall be reimbursed at 60% of the HCP Fee Schedule for a four-hour appointment.
Independent Medical Examination (IME)	A worker fails to provide a two-business day notice of cancellation of an IME	The missed appointment shall be reimbursed at either 60% of the preapproved fee or 60% of the HCP's usual and customary fee if a fee was not preapproved.
Psychotherapy (90832, 90834, 90837), Psychological/Neuropsychological Testing (96116, 96130-96139), Cognitive Performance Testing (96125), Behavioral Screening/Testing (96127)	A new patient fails to provide a two-business day notice of cancellation	The missed appointment shall be reimbursed at 60% of the HCP fee schedule.

Free-Standing Ambulatory Surgery Center

For outpatient surgery performed in a New Mexico or out-of-state free-standing ambulatory surgery center (FASC), the Centers for Medicare and Medicaid Services Ambulatory Payment Classification (CMS-APC) base payment rate shall be used to calculate the reimbursement amount for the service(s) performed. The date of service shall coincide with the appropriate quarterly Addendum. No adjusted conversion factors or index values are to be applied.

CMS-APC Base Payment Rate X 1.3

The CMS-APC can be found under Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

If no assigned CMS-APC base payment rate is indicated, the services shall be reimbursed at the HCP Fee Schedule x 1.3.

HCPs billing for professional services related to outpatient surgery performed in a FASC shall be reimbursed per the HCP Fee Schedule.

Multiple outpatient surgeries follow cascade payment of full, half, half (CMS-APC) until fourth and subsequent procedure(s) which shall be reimbursed at 50% of the CMS-APC x 1.3.

Coding and billing separately for procedures that do not warrant separate identification because they are an integral part of a service for which a corresponding CPT code exists, also known as unbundling, is prohibited.

Global Surgery

Payment for surgical procedures includes a standard global package which includes all necessary services normally furnished by a surgeon before, during and after a procedure. The HCP Fee Schedule includes the preoperative, intraoperative and postoperative services routinely performed by a surgeon. Physicians in the same group practice who

are in the same specialty must bill and be paid as though they were a single physician. Preoperative and postoperative periods will differ based on the classification of the service as a major or minor surgery.

The preoperative period included in the global fee for ***major surgery*** is one day with a postoperative period of 90 days.

The preoperative period included in the global fee for ***minor surgery*** is the day of the procedure with a postoperative period of either zero or ten days depending on the procedure.

For endoscopic procedures (except procedures requiring an incision), there is no postoperative period.

Hospitals

Ratios

~~New hospitals shall be assigned an initial ratio of 0.67~~

All New Mexico hospitals, including rehabilitation hospitals, ~~shall provide to the WCA the most recent full year filing of their HCFA/CMS 2552 G-2worksheet prepared on behalf of the organization pursuant to Section 52-5-21 NMSA 1978.~~ shall be reimbursed according to the methodology set forth in this section of the HCP Fee Schedule.

The assigned ratio is applied toward all charges for compensable services provided during a hospital inpatient stay and emergency department visit.

The ratio does not apply to procedures that are performed in support of surgery, even if performed on the same day and at the same surgical site as the surgery.

By May 1 of each calendar year, all hospitals shall provide to the WCA the most recent full year filing of their HCFA/CMS 2552 G-2 worksheet prepared on behalf of the organization. A hospital may specifically designate this worksheet as proprietary and confidential. Any worksheet specifically designated as proprietary and confidential in good faith shall be deemed confidential pursuant to Section 52-5-21 NMSA 1978 and the rules promulgated pursuant to that provision. Failure to comply may result in fines and penalties.

A written appeal of the assigned hospital ratio may be filed with the director within 30 days of the assignment of the ratio. The director will review the appeal and respond with a written determination. The director may require the hospital to provide additional information prior to a determination and in his discretion may conduct a hearing. The director's written determination shall be issued within 30 days of the final submission of all information regarding the appeal to the director. The director's written determination shall be final.

If a G-2 worksheet is not received by the WCA, the facility will be assigned a ratio equal to the median for all expenditures/revenue.

New hospitals shall be assigned an initial ratio of 0.67

HOSPITAL	LOCATION	RATIO
Advanced Care Hospital of Southern NM	Las Cruces	~~.44~~.45

HOSPITAL	LOCATION	RATIO
Albuquerque – AMG Specialty Hospital	Albuquerque	.41.37
Alta Vista Regional Hospital	Las Vegas	.41.37
Artesia General Hospital	Artesia	.43.38
Carlsbad Medical Center	Carlsbad	.41.37
Cibola General Hospital	Grants	.49.50
Dr. Dan C. Trigg Memorial Hospital (PHS)	Tucumcari	.60.60
Eastern New Mexico Medical Center	Roswell	.41.37
Encompass Health Rehabilitation Hospital (formerly HealthSouth)	Albuquerque	.58
Española Hospital (PHS)	Española	.44.44
Gerald Champion Regional Medical Center	Alamogordo	.41.37
Gila Regional Medical Center	Silver City	.46.37
Guadalupe County Hospital	Santa Rosa	.53.60
~~HealthSouth Rehabilitation Hospital~~	~~Albuquerque~~	~~.54~~
Heart Hospital of NM at Lovelace Medical Center	Albuquerque	.41.37
Holy Cross Hospital	Taos	.48.54
Kaseman Hospital (PHS)	Albuquerque	.41.39
Kindred Hospital Albuquerque	Albuquerque	.41.37
Lea Regional Hospital	Hobbs	.41.37
Lincoln County Medical Center (PHS)	Ruidoso	.50.50
Los Alamos Medical Center	Los Alamos	.41.37
Lovelace Medical Center – Downtown	Albuquerque	.41.37
Lovelace Regional Hospital – Roswell	Roswell	.41.37
Lovelace Rehabilitation Hospital	Albuquerque	.41.37
Lovelace Westside Hospital	Albuquerque	.41.37
Lovelace Women's Hospital	Albuquerque	.41.37
Memorial Medical Center	Las Cruces	.41.37

HOSPITAL	LOCATION	RATIO
Mesilla Valley Hospital	Las Cruces	.41.37
Mimbres Memorial Hospital	Deming	.41.37
Miners' Colfax Medical Center	Raton	.75.75
Mountain View Regional Medical Center	Las Cruces	.41.37
New Mexico Rehabilitation Center	Roswell	.41.37
Nor-Lea Hospital	Lovington	.41.37
Plains Regional Medical Center (PHS)	Clovis	.41.37
Presbyterian Hospital (PHS)	Albuquerque	.41.39
Presbyterian Rust Medical Center (PHS)	Rio Rancho	.41.39
Rehabilitation Hospital of Southern NM	Las Cruces	.62.65
Rehoboth McKinley Christian Hospital	Gallup	.41.38
Roosevelt General Hospital	Portales	.41.37
San Juan Regional Medical Center	Farmington	.41.37
San Juan Regional Rehabilitation Hospital	Farmington	.52.37
Santa Fe Medical Center	Santa Fe	.55
Sierra Vista Hospital	Truth or Consequences	.59.63
Socorro General Hospital (PHS)	Socorro	.59
St. Vincent Hospital	Santa Fe	.41.37
Union County General Hospital	Clayton	.75
University of New Mexico Hospital	Albuquerque	.57.59
UNM Sandoval Regional Medical Center	Rio Rancho	.43.43

Hospital Inpatient

The hospital ratio shall be applied to all charges for compensable services including room and board charges provided during a hospital inpatient stay, including inpatient surgery or an emergency department visit with the exception of Implants, Hardware and Instrumentation, and Radiology, Pathology and Laboratory.

- Implants, Hardware and Instrumentation shall be paid at HCP Invoice Cost x 1.25 + Shipping & Handling and NMGRT.

- Radiology, Pathology and Laboratory shall be paid at .60 of the HCP Fee Schedule for the technical component of the service.

Multiple surgery rules do not apply to hospital ratio items. Each line is paid separately and not bundled or inclusive to any other services performed.

Physical therapy and occupational therapies performed in an inpatient hospital setting shall be paid at the assigned hospital ratio.

Hospital Outpatient

Services performed in an outpatient or emergency department visit are paid at the assigned hospital ratio with the exception of Implants, Hardware and Instrumentation, and Radiology, Pathology and Laboratory, and Surgery.

- Implants, Hardware and Instrumentation shall be paid at HCP Invoice Cost x 1.25 + Shipping & Handling and NMGRT.

- Radiology, Pathology and Laboratory shall be paid at .60 HCP Fee Schedule for the technical component of the service.

- Surgery (Revenue Code 36X) shall be paid as follows:

  For outpatient surgery performed in a hospital, the Centers for Medicare and Medicaid Services Ambulatory Payment Classification (CMS-APC) base payment rate shall be used to calculate the reimbursement amount for the service(s) performed.

  The date of service shall coincide with the appropriate quarterly Addendum. No adjusted conversion factors or index values are to be applied.

  CMS-APC Base Payment Rate X 1.3

  The CMS-APC can be found under Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

  If no assigned CMS-APC base payment rate is indicated, the services shall be paid at HCP Fee Schedule x 1.3.

  Multiple outpatient surgeries follow cascade payment of full, half, half (CMS-APC) until fourth and subsequent procedure(s) which shall be reimbursed at 50% of the APC x 1.3.

When physical therapy and occupational therapies are performed in an outpatient hospital setting and no other services are rendered, the reimbursement shall be paid per the HCP Fee Schedule.

HCPs billing for professional services related to outpatient surgery shall be reimbursed per the HCP Fee Schedule.

Coding and billing separately for procedures that do not warrant separate identification because they are an integral part of a service for which a corresponding CPT code exists, also known as unbundling, is prohibited.

Out-of-State Hospitals

Out-of-state hospitals shall be reimbursed using a hospital ratio of .~~41~~.37, according to the guidelines listed above.

Hospital Venipuncture

Routine venipuncture is not a laboratory CPT code but rather a surgical CPT code and shall be reimbursed using the appropriate hospital ratio when performed during inpatient, outpatient or emergency room treatment.

Implants, Hardware and Instrumentation

Implants, hardware and instrumentation implanted or installed during surgery, including those that take place in a hospital, shall be reimbursed as follows:

HCP Invoice Cost	**X**	**1.25**	**+**	**Shipping & Handling and NMGRT**

The HCP shall provide a copy of the invoice at the time of the billing or upon the payer's request.

Materials and Supplies

Materials and supplies shall be itemized and billed using CPT Code 99070 and shall be reimbursed as follows:

HCP Invoice Cost	**X**	**1.25**	**+**	**Shipping & Handling and NMGRT**

The HCP shall provide a copy of the invoice at the time of the billing or upon the payer's request.

An HCP that uses a medication(s) during an in-office procedure shall bill and be reimbursed as per this section of the HCP Fee Schedule.

Billing for this medication(s) shall include the National Drug Code (NDC) number.

Medical Cannabis

Maximum quantity subject to reimbursement is ~~230~~ up to 425 units~~, or up to 345 units with a written recommendation from the authorized HCP,~~ per rolling 90-day period.

Reimbursement shall be made using the following conversion:

- 1 unit ≈ 200 mg THC (≈ 1-gram dry weight equivalent)
- Maximum Reimbursable Amount = $11.~~81~~60 per unit (i.e., per 1-gram dry weight equivalent)

Reimbursement of medical cannabis should be included in the carriers' Annual Expenditure Report (AER) submission per ~~NM~~WCA rules.

Miscellaneous Fees

Copies

No party may be charged for the initial copy of medical records at the time of billing. Parties may be charged for second and subsequent copies of any medical records in the following ways:

- For paper copies, an HCP may charge up to one dollar ($1.00) per page for the first 10 pages and up to twenty cents ($0.20) for each page thereafter, except as provided in Subsection C of 11.4.7.8 NMAC. This fee is inclusive of any and all fees, including, but not limited to, administrative, processing, and handling fees of any kind.

- For electronic copies, an HCP may charge up to fifty cents ($0.50) per page for the first 10 pages and up to ten cents ($0.10) for each page thereafter, except as provided in Subsection C of 11.4.7.8 NMAC. This fee is inclusive of any and all fees, including, but not limited to, administrative, processing, and handling fees of any kind.

No party may be charged for medical records submitted to the ~~NM~~WCA's case management/utilization or peer review contractor for required information.

Form Letter to Health Care Provider

An HCP who completes the *WCA Form Letter to Health Care Provider* shall bill using CPT code 99080 and be reimbursed the equivalent of CPT Code 99214 as found in the HCP Fee Schedule at the time of completion of the *WCA Form Letter*.

New Mexico Gross Receipts Tax (NMGRT)

If NMGRT is included on a bill from an HCP, the payer is responsible for reimbursing the HCP for the appropriate gross receipts tax in addition to the HCP Fee Schedule payment.

Providers whose corporate tax status requires them to pay NMGRT shall bill in one of the following ways:

- On the billing form next to the "total charges," print or stamp "NMGRT must be added to final payment calculation" along with the appropriate tax rate percentage.

- Below the "total charges," add the NMGRT amount, listing the appropriate tax rate percentage. Add this amount to the "total charges" to determine the "total amount billed".

- Another method, agreed upon in advance by both the Billing entity and the Payer, may be used, provided that in all cases, the invoice clearly identifies that NMGRT applies, and accurately includes the correct NMGRT rate that applies.

- If NMGRT is not noted on the billing form, the bill would be paid either according to the HCP Fee Schedule or the billed

amount, whichever is less.

Radiographic Files

Charges for copies of radiographic files (X-rays) may be billed to the requestor by the X-ray facility following by-report (BR) procedures.

Referrals and Consultations

If an initial consultation was already completed by a provider and that same provider is now the referred provider and will manage all or part of the patient's care, only established E/M codes shall be used.

If a provider who has been requested to examine a patient assumes **immediate** responsibility for primary care of that patient, it shall be considered a referral and not a consultation. Only E/M codes shall be used.

For the first visit only, a new patient code may be used.

National Correct Coding Initiative (NCCI) Edits

The New Mexico Workers' Compensation Administration does not follow the National Correct Coding Initiative (NCCI) edits.

The New Mexico Workers' Compensation Administration follows the guidelines provided in the American Medical Association's CPT codebook edition that corresponds with the annual WCA Director's Fee Schedule Order.

Pharmacy

Average Wholesale Price (AWP)

The formula for billing generic and brand name prescription drugs:

Pharm MAP = $ AWP X .90 + $5.00 dispensing fee

The formula for billing generic and brand name prescription drugs *when not dispensed by a licensed pharmacy*:

$ AWP X .90 (no dispensing fee included)

Any nationally recognized monthly or weekly publication that lists the AWP may be used to determine the AWP. The date that shall be used to determine the AWP and calculation of the Pharm MAP shall be the date on which the drugs were dispensed, regardless of the AWP changes during the month.

Use of a prorated calculation of the AWP will often be necessary in the formulas. For each drug dispensed, the prorated AWP shall be based on the AWP for the "100s each" quantity of the specific strength of the drug, as listed in a nationally recognized publication, with the following exceptions:

- If an AWP listed in the publication is based on the exact quantity of the dispensed drug, e.g., #15, #60, 15

ml, 3.5 gm, etc., the AWP for the exact quantity shall be used with no prorating calculation made.

- If the drug is dispensed as a quantity based on volume (grams, ounces, milliliters, etc.), rather than single units (each), the prorated AWP shall be calculated in accordance with the highest quantity (volume) listed for the specific strength of the drug.

- In cases of a conflict between referenced publications, the lower price shall prevail.

Pharmacies and authorized HCPs must include patient identification and information. No specific form is required. Any bill that is submitted without an NDC number will be paid at the lowest AWP available for the month in which the drug(s) was dispensed.

An HCP that uses medication(s) during an in-office procedure shall bill and be reimbursed according to the **Materials and Supplies** section of the HCP Fee Schedule.

Compound Medications

Compounding includes combining drug ingredients to meet specific patient medication needs.

Compound medications shall be reimbursed at the ingredient level, with each ingredient identified using the applicable NDC registered with the Food & Drug Administration (FDA), of the drug product and the corresponding quantity.

When dispensed by a licensed pharmacy, the formula for billing generic and brand name compound medications is as follows:

$ AWP X .90 + $5.00 dispensing fee

When not dispensed by a licensed pharmacist, the formula for billing generic and brand name compound medications is as follows:

$ AWP X .90 (no dispensing fee included)

All bills submitted for compounded products must include the NDC number of the original manufacturer registered with the FDA or its authorized distributor's stock package used in the compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP of the ingredient(s), calculated on a per unit basis, as of the date of dispensing. A repackaged drug NDC number shall not be used and shall not be considered the original manufacturer's NDC number. If the original manufacturer's NDC number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis.

Ingredients with no NDC number shall not be separately reimbursable. Payment shall be based upon the sum of the allowable fee for each ingredient plus a single dispensing fee per compound.

Compounded medications not dispensed by a licensed pharmacy:

- Shall not exceed a ten (10) day supply for a new prescription only;

- Shall not exceed the cost of a generic equivalent [see NMAC 11.4.7.9.C.(6)].

Any compounded medications dispensed and administered in excess of a 24-hour supply to a registered emergency room patient shall be paid according to the hospital ratio [see NMAC 11.4.7.9.B(1).

Reimbursement is the lesser of the HCP Fee Schedule, Usual and Customary Fee or contract charges. No specific billing form is required.

Physical Therapy

Physical therapy bills may include all codes which are reasonable and necessary for the evaluation and treatment of a worker in a single day. Physical therapy evaluation codes are appropriate. However, traditional E/M codes are not appropriate for this purpose.

All timed physical therapy CPT codes are paid individually regardless of the cumulative, total time spent. For timed CPT codes, a unit of time is attained when the mid-point has passed.

Platelet Rich Plasma (PRP) Injection

PRP injections shall be billed using CPT code 99199. This procedure includes image guidance, harvesting and preparation when performed. The appropriate reimbursement for the PRP procedure is $850 plus applicable NMGRT.

The required PRP kit is billed as a separate line item under Materials and Supplies and shall be reimbursed as such.

Provider's Report of Physical Ability

The *WCA Provider's Report of Physical Ability (PROPA), 2022 revision* is available to all parties on the WCA agency website. It is also linked here: https://workerscomp.nm.gov/sites/default/files/documents/forms/PROPA_fillable.pdf

The PROPA shall be billed for reimbursement if pre-authorization is obtained AND if it is completed at the providers initial visit or if there is a change in Work Status (section 2 of the PROPA) or Activity Restrictions (section 3 of the PROPA).

Completion of the PROPA shall be billed as a separate line item along with the appropriate evaluation code for the appointment.

The PROPA shall be billed using CPT code 99080 and shall be reimbursed $25.00.

- For the initial visit, the medical notes must indicate "WCA Provider's Report of Physical Ability – Initial.
- For established patients, the medical notes must indicate "WCA Provider's Report of Physical Ability Change".

Service Component Modifiers for Hospitals, FASCs and Outpatient Services

RADIOLOGY including nuclear medicine and diagnostic ultrasound (CPT 70010-79999) and **PATHOLOGY/LABORATORY** (CPT 80047-89398)	Paid at rates equivalent to those set forth in the most current version of the HCP Fee Schedule. The dollar values listed in the HCP Fee Schedule for a specific radiology or pathology/laboratory procedure represent the professional service reimbursement, the technical service reimbursement as well as the total maximum allowable payment.
	Modifier Codes: Use of the technical modifier code "TC" and the professional modifier code "26" are required for the billing of all radiology and pathology/ laboratory procedures unless the same HCP is performing both the technical and professional component of a service (global), no modifier shall be reported. The global services shall be paid at 100% of the total maximum allowable payment as shown in the HCP Fee Schedule.
	A detailed billing breakdown of the professional and technical components of the services shall be provided.
	The technical component of the service "TC" shall be paid at no more than 60% of the maximum allowable payment as shown in the HCP Fee Schedule.
	The professional component of the service "26" shall be paid at no more than 40% of the maximum allowable payment as shown in the HCP Fee Schedule.
	Radiology and pathology/laboratory procedures billed by a hospital without a modifier shall be paid at the TC rate (60% of the maximum allowable payment as shown in the HCP Fee Schedule).

Surgical Modifiers for FASCs and HCP Professional Services

	FASC'S	HCP PROFESSIONAL SERVICES
BILATERAL PROCEDURE "50"		
When performed during the same operative session, the first or major procedure shall be coded with the appropriate CPT code **without a modifier**	Paid at the lesser of the billed charges or the APC base payment rate times 1.3	Paid at the lesser of the billed charges or 100% of the HCP Fee Schedule
The *second* procedure shall be coded with the same CPT code **plus the "50" modifier code**	Paid at no more than 50% of the APC base payment rate times 1.3	Paid at 50% of the HCP Fee Schedule
MULTIPLE PROCEDURES "51"		
The *primary or major* procedure shall be coded with the appropriate CPT code **without a modifier**	Paid at the lesser of the billed charges or the APC base payment rate times 1.3	Paid at the lessor of the billed charges or 100% of the HCP Fee Schedule
The *second and third* procedure shall be coded with the respective CPT code **plus the modifier code "51"**	Paid at 50% of the APC base payment rate times 1.3	Paid at 50% of the HCP Fee Schedule
The *fourth and subsequent* procedures	Paid at 50% of the APC base payment rate times 1.3	Paid at 50% of the HCP Fee Schedule
As clarification, all add-on CPT codes found in the CPT code book are payable and are exempt from the multiple procedure guidelines, e.g., the -51 modifier should not be appended to a designated add-on or exempt code (see CPT Appendices D & E).		

SURGEON	HCP PROFESSIONAL SERVICES
The *attending surgeon* shall bill using the appropriate CPT code(s) **and modifiers, if applicable,** for the procedure(s) performed	Paid at the lesser of the billed charges or the HCP Fee Schedule, subject to the percentages for modifiers in this section
The *assistant surgeon* ("80") shall bill using the appropriate CPT code(s) **plus the modifier** for the procedure(s) performed	Paid at no more than 25% of the HCP Fee Schedule.
The *minimum assistant surgeon* ("81") shall bill using the appropriate CPT code(s) **plus the modifier** for the procedure(s) performed	Paid at no more than 15% of the HCP Fee Schedule.
The *assistant surgeon* ("82) (when a qualified resident surgeon is not available) shall bill using the appropriate CPT code(s) **plus the modifier** for the procedure(s) performed	Paid at no more than 25% of the HCP Fee Schedule.
A *Physician Assistant, Nurse Practitioner, or Certified Nurse* Specialist ("AS") shall bill using the appropriate CPT code(s) **plus the modifier** for the procedure(s) performed	Paid at no more than 22% of the HCP Fee Schedule.
A *Co-Surgeon* ("62") shall bill using the appropriate CPT code(s) **plus the modifier** for the procedure(s) performed	Paid at no more than 62.5% of the HCP Fee Schedule.

Telehealth

Telemedicine Services

- Providers must append modifier 95 to the appropriate CPT code and bill the appropriate location place of service code.

- Modifier 95 refers to "synchronous telemedicine service rendered via a real-time interactive audio and video" and is appropriate for use with all traditional "telemedicine" visits.

- Providers should list the same place of service (POS) code that would have been used had the service been provided in person.

  Telemedicine may be used for both the initial and subsequent visits.

Telephonic Services

- Physicians and non-physicians would utilize the appropriate CPT codes.

Urine Drug Testing

Urine drug testing for chronic opioid therapy that is conducted in accordance with the Prescription Monitoring Program (PMP) regulations in the applicable jurisdiction shall be considered reasonable and necessary treatment.

Urine drug testing may be included in services provided during an office visit but can be billed and paid separately using an applicable drug screen CPT code.

CPT codes 80305, 80306 and 80307 will be eligible for one (1) unit of reimbursement per date of service.

APPENDIX A – CPT-CODED HCP FEE SCHEDULE