TITLE 11 LABOR AND WORKERS' COMPENSATION
CHAPTER 4 WORKERS' COMPENSATION
PART 7 PAYMENTS FOR HEALTH CARE SERVICES

11.4.7.1 ISSUING AGENCY: Workers' Compensation Administration (WCA).
[11.4.7.1 NMAC - Rp, 11.4.7.1 NMAC, 12-31-13]

11.4.7.2 SCOPE: This rule applies to workers, employers, and insurers and to all workers' compensation health care services providers, caregivers, pharmacies, and suppliers and all payers for such services and supplies.
[11.4.7.2 NMAC - Rp, 11.4.7.2 NMAC, 12-31-13; A, 09-30-16]

11.4.7.3 STATUTORY AUTHORITY: Sections 52-1-1, 52-3-1, 52-4-1, 52-4-2, 52-4-3, 52-4-5, 52-5-4, and 52-10-1 NMSA 1978.
[11.4.7.3 NMAC - Rp, 11.4.7.3 NMAC, 12-31-13; A, 9-30-16]

11.4.7.4 DURATION: Permanent.
[11.4.7.4 NMAC - Rp, 11.4.7.4 NMAC, 12-31-13]

11.4.7.5 EFFECTIVE DATE: December 31, 2013, unless a later date is cited at the end of a section.
[11.4.7.5 NMAC - Rp, 11.4.7.5 NMAC, 12-31-13]

11.4.7.6 OBJECTIVE: The purpose of these rules is to establish and enforce a system of maximum allowable fees and reimbursements for health care services and related non-clinical services provided by all practitioners, to establish billing dispute procedures and to establish the procedures for cost containment, including case management and utilization review services.
[11.4.7.6 NMAC - Rp, 11.4.7.6 NMAC, 12-31-13; A, 09-30-16]

11.4.7.7 DEFINITIONS: The definitions in11.4.1.7 NMAC shall apply to this rule. In addition, the following definitions apply to the provision of all services.

A. "Business day" means any day on which the WCA is open for business.

B. "Cannabis Program" means the State of New Mexico Department of Health Medical Cannabis Program.

C. "Caregiver" means any provider of health care services not defined and specified in Section 52-4-1 NMSA 1978.

D. "Case management" means the on-going coordination of health care services provided to an injured or disabled worker including, but not limited to:

(1) developing a treatment plan to provide appropriate health care service to an injured or disabled worker;

(2) systematically monitoring the treatment rendered and the medical progress of the injured or disabled worker;

(3) assessing whether alternate health care services are appropriate and delivered in a cost-effective manner based upon acceptable medical standards;

(4) ensuring that the injured or disabled worker is following the prescribed health care plan; and,

(5) formulating a plan for the return to work.

E. "Contractor" means any organization that has a legal services agreement currently in effect with the workers' compensation administration (WCA) for the provision of utilization review or case management or peer review services.

F. "Current procedural terminology ("CPT")" means a systematic listing and coding of procedures and services performed by HCPs of the American medical association, adopted in the director's annual order. Each procedure or service is identified with a numeric or alphanumeric code (CPT code). This was developed and copyrighted by the American medical association. The five character codes included in the rules governing the health care provider fee schedule are obtained from current procedural terminology (CPT®), copyright 2015 by the American medical association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of the rules governing the health care provider fee schedule is with WCA and no

endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in rules governing the health care provider fee schedule. Fee schedules, relative value units, conversion factors or related components are not assigned by the AMA, are not part of CPT, and AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of rules governing the health care provider fee schedule should refer to the most recent edition of the current procedural terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DRARS apply. CPT is a registered trademark of the American medical association.

G. "Diagnostic and statistical manual of mental disorders (DSM)" means the current edition of the manual, which lists and describes the scientifically diagnosed mental disorders and is commonly referred to as "DSM".

H. "Department of health (DOH)" means the state of New Mexico department of health.

I. "Director" means director of the workers' compensation administration (WCA) or designee.

J. "Durable medical equipment (DME)" means supplies and equipment that are rented, leased, or permanently supplied to a patient and which have been prescribed to aid the recovery or improve the function of an injured or disabled worker.

K. "Employer" means, collectively: an employer subject to the act; a self-insured entity, group or pool; a workers' compensation insurance carrier or its representative; or any authorized agent of an employer or insurance carrier, including any individual owner, chief executive officer or proprietor of any entity employing workers.

L. "Freestanding ambulatory surgical center (FASC)" means a separate facility that is licensed by the New Mexico department of health as an ambulatory surgical center.

M. "Health care provider (HCP) or provider" means any person, entity, or facility authorized to furnish health care to an injured or disabled worker pursuant to Section 52-4-1 NMSA 1978, including any provider designated pursuant to Section 52-1-49 NMSA 1978, and may include a provider licensed in another state if approved by the director, as required by the act. The director has determined that certified registered nurse anesthetists (CRNAs) and certified nurse specialists (CNSs) who are licensed in the state of New Mexico are automatically approved as health care providers pursuant to Section 52-4-1(P) NMSA 1978.

N. "Hospital" means any place currently licensed as a hospital by the department of health pursuant to Section 52-4-1(A) NMSA 1978, where services are rendered within a permanent structure erected upon the same contiguous geographic location as are all other facilities billed under the same name.

O. "Implants, instrumentation and hardware" means:

(1) surgical implants are defined as any single-use item that is surgically inserted, deemed to be medically necessary and approved by the payer which the physician does not specify to be removed in less than six weeks, such as 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 neurostimulators; and pain pumps;

(2) disposable instrumentation includes ports, single-use temporary pain pumps, external fixators and temporary neurostimulators and other single-use items intended to be removed from the body in less than six (6) weeks.

P. "Independent medical examination (IME)" means a specifically requested evaluation of an injured or disabled worker's medical condition performed by an HCP, other than the treating provider, as provided by Section 52-1-51 NMSA 1978.

Q. "Licensed producer" means an individual or entity located in New Mexico licensed and certified by the department of health to produce, manufacture, or dispense medical cannabis.

R. "Medical cannabis" means medical cannabis in the form of flower, bud, cannabis derived products, edibles, oils, tinctures, or any other form regulated by the department of health.

S. "Medical records" means:

(1) all records, reports, letters, and bills produced or prepared by an HCP or caregiver relating to the care and treatment rendered to the worker;

(2) all other documents generally kept by the HCP or caregiver in the normal course of business relating to the worker, including, but not limited to, clinical, nurses' and intake notes, notes evidencing the patient's history of injury, subjective and objective complaints, diagnosis, prognosis or restrictions, reports of diagnostic testing, hospital records, logs and bills, physical therapy records, and bills for services rendered, but does not include any documents that would otherwise be inadmissible pursuant to Section 52-1-51(C) NMSA 1978.

T. "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"). This tax is collected by the New Mexico taxation and revenue department.

U. "Peer review" means an individual case by case review of services for medical necessity and appropriateness conducted by an HCP licensed in the same profession as the HCP whose services are being reviewed.

V. "Physical impairment ratings (PIR)" means an evaluation performed by an MD, DO, or DC to determine the degree of anatomical or functional abnormality existing after an injured or disabled worker has reached maximum medical improvement. The impairment is assumed to be permanent and is expressed as a percent figure of either the body part or whole body, as appropriate, in accordance with the provisions of the Workers' Compensation Act and the most current edition of the American medical association's guides to the evaluation of permanent impairment (AMA guide).

W. "Prescription drug" means any drug, generic or brand name, which requires a written order from an authorized HCP for dispensing by a licensed pharmacist or authorized HCP.

X. "Referral" means the sending of a patient by the authorized HCP to another practitioner for evaluation or treatment of the patient and it is a continuation of the care provided by the authorized HCP.

Y. "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.

Z. "Unlisted service or procedure" means a service performed by an HCP or caregiver which is not listed in the edition of the American medical association's current procedural terminology referenced in the director's annual order or has not otherwise been designated by these rules.

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

BB. "Utilization review" means the evaluation of the necessity, appropriateness, efficiency, and quality of health care services provided to an injured or disabled worker and may include peer group utilization review of selected provider services as set forth in Section 52-4-2 NMSA 1978.

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

[11.4.7.7 NMAC - Rp, 11.4.7.7 NMAC, 12-31-13; A, 10-1-15; A, 09-30-16]

11.4.7.8 GROUND RULES FOR BILLING AND PAYMENT:

A. Basic ground rules.

(1) These rules apply to all charges and payments for medical, other health care treatment, and related non-clinical services covered by the New Mexico Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law.

(2) These rules shall be interpreted to the greatest extent possible in a manner consistent with all other rules promulgated by the WCA. In the event of an irreconcilable conflict between these rules and any other rules, the more specific set of rules shall control.

(3) Nothing in these rules shall preclude the separate negotiation of fees between a provider and a payer within the health care provider fee schedule for any health care service as set forth in these rules.

(4) These rules and the director's annual order adopting the health care provider fee schedule utilize the edition of the current procedural terminology referenced in the director's annual order, issued pursuant to Subsection A of 11.4.7.9 NMAC. All references to specific CPT code provisions in these rules shall be modified to the extent required for consistency with the director's annual order.

(5) Employers are required to inform a worker of the identity and source of their coverage for the injury or disablement.

B. Authorization for treatment and services.

(1) A provider or inpatient facility may seek pre-authorization from payer for all services or treatment plans. If authorization is sought, all requests for authorization of referrals and all other procedures shall be approved or denied by the payer within five business days of receipt of all supporting documentation and no later than five business days before the procedure.

(2) Once a worker has been admitted to an inpatient facility, all requests for authorization of referrals and procedures during the inpatient stay shall be approved or denied by the payer by the close of the next business day after receipt of all supporting documentation.

(3) If an authorization or denial is not received by the provider by the deadlines set forth in this rule, the requested service or treatment will be deemed authorized. The provider shall document all attempts to obtain authorization from the date of the initial request.

(4) A payer shall not be required to respond to a provider's request for authorization within the deadlines set forth in this rule if the payer has previously denied a claim in writing.

(5) Pre-authorization is required prior to scheduling or performing any of the following services:

(a) independent medical examinations;
(b) physical impairment ratings;
(c) functional capacities evaluations;
(d) physical therapy;
(e) caregiver services; and
(f) durable medical equipment (DME).

C. Billing provision ground rules.

(1) Billing shall be made in accordance with billing instructions issued by the director in conjunction with the annual fee order.

(2) Submitting a bill to any party for the difference between the usual and customary charges and the maximum amount of reimbursement allowed for compensable health care services or items, also known as balance billing, is prohibited.

(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.

(4) The appropriate CPT code must be used for billing by providers.

(5) Initial billing of outpatient services by providers, hospitals and FASC's, shall be submitted no later than 30 days from the end of the month in which services were rendered. Initial billing of inpatient services shall be issued no later than 60 days from the date of discharge.

(6) Failure of the provider to submit the initial billing within the time limits provided by these rules shall constitute a violation of these rules but does not absolve the employer of financial responsibility for the bill.

(7) Unlisted services or procedures are billable and payable on a by-report (BR) basis as follows:

(a) The fee for the performance of any BR service shall be negotiated between the provider and the payer prior to delivery of the service. Payers should ensure that a CPT code with an established fee schedule amount is not available.

(b) Performance of any BR service requires that the provider submit a written report, for which no separate charge is allowed, with the billing to the payer. The report shall substantiate the rationale for not using an established CPT code and shall include pertinent information regarding the nature, extent, and special circumstances requiring the performance of that service and an explanation of the time, effort, personnel, and equipment necessary to provide the service.

(c) Information provided in the medical record(s) may be submitted in lieu of a separate report if that information satisfies the requirements of Paragraph (10) of Subsection C of 11.4.7.8 NMAC.

(d) In the event a dispute arises regarding the reasonableness of the fee for a BR service, the provider shall make a prima facie showing that the fee is reasonable. In that event, the burden of proof shall shift to the payer to show why the proposed fee is not reasonable.

(8) If payer and provider agree to enter into a global fee agreement at any time, a global fee can be used. All services not covered by the global fee agreement shall be coded and paid separately, to the extent substantiated by medical records. Agreement to use a global fee creates a presumption that the HCP will be allowed to continue care throughout the global fee period.

(9) If a service that is ordinarily a component of a larger service is performed alone for a specific purpose it may be considered a separate procedure for coding, billing, and payment purposes. Documentation in the medical records must justify the reasonableness and necessity for providing such services alone.

(10) Initial bills for every visit shall be accompanied by appropriate office notes (medical records) which clearly substantiate the service(s) being billed and are legible.

(11) Records provided by hospitals and FASCs shall have a copy of the admission history and physical examination report and discharge summary, hospital emergency department medical records, imaging, ambulatory surgical center medical records or outpatient surgery records.

(12) No charge shall be made to any party to the claim for the initial copy of required information.

(13) The worker shall not be billed for health care services provided by an authorized HCP as treatment for a valid workers' compensation claim unless payer denies compensability of a claim or payer does not respond to a bill within the time limit set forth in Paragraph (2) of Subsection D of 11.4.7.8 NMAC.

(14) Diagnostic coding shall be consistent with the most current version of the international classification of diseases, clinical modification or diagnostic and statistical manual of mental disorders guidelines required by CMS as appropriate.

(15) For any reimbursement under the fee schedule or these rules that is based upon provider's cost, the provider shall submit a copy of the invoice showing that cost either at the time of billing or upon the payer's request.

(16) The health care facility is required to submit all requested data to the payer. Failure to do so could result in fines and penalties imposed by the WCA. All payers are required to notify the economic research bureau of unreported data fields within 10 days of payment of any inpatient bill.

D. Payment provision ground rules.

(1) The provision of services gives rise to an obligation of the employer to pay for those services. Accordingly, all services are controlled by the rules in effect on the date the services were provided.

(2) For all reasonable and necessary services provided to a worker with a valid workers' compensation claim, payer is responsible for timely good faith payment within 30 days of receipt of a bill for services unless payment is pending in accordance with the criteria for contesting bills and an appropriate explanation of benefits has been issued by the payer. Payment for non-contested portions of any bill shall be timely.

(3) Effective July 1, 2013, all medical services rendered pursuant to recommended treatment contained in the most recent edition of the official disability guidelines™ (ODG) is presumed reasonable and necessary pursuant to Section 52-1-49(A) NMSA 1978; there is no presumption regarding any other treatment.

(4) If a service has been pre-authorized or is provided pursuant to a treatment plan that has been pre-authorized by an agent of the payer, it shall be presumed that the service provided was reasonable and necessary. The presumption may be overcome by competent evidence that the payer, in the exercise of due diligence, did not know that the compensability of the claim was in doubt at the time that the authorization was given.

(5) An employer who subcontracts bill review services remains fully responsible for compliance with these rules.

(6) Fees and payments for all physician professional services, regardless of where those services are provided, are reimbursed within the health care provider fee schedule.

(7) Bills may be paid individually or batched for a combined payment; however, each service, date of service and the amount of payment applicable to each procedure must be appropriately identified.

(8) All bills shall be paid in full unless one or more of the following criteria are met. These criteria are the only permissible reasons for contesting workers' compensation bills submitted by authorized providers:

(a) compensability is denied;

(b) services are deemed not to be reasonable and necessary;

(c) incomplete billing information or support documentation;

(d) inaccurate billing or billing errors; or

(e) reduction specifically authorized by this rule.

(9) Whenever a payer contests a bill or the payment for services is denied, delayed, reduced or otherwise differs from the amount billed, the payer shall issue to the provider a written EOB which shall clearly relate to each payment disposition by procedure and date of service. Only the EOBs listed in WCA billing instructions may be used.

(10) Failure of the payer to indicate the appropriate EOB(s) constitutes an independent violation of these rules.

(11) The prorating of the provider's fees for time spent providing a service, as documented in the provider's treatment notes, is not prohibited by these rules provided an appropriate EOB is sent to the provider.

Evaluation and management CPT codes shall not be prorated. The provider's fees should not be prorated to exclude time spent in pre- and post-treatment activity, such as equipment setup, cleaning, disassembly, etc., if it is directly incidental to the treatment provided and is adequately documented.

(12) A request for reconsideration, if any, shall be submitted to the payer within 30 days of receipt of the payer's disposition. Failure to comply with the deadline for a request for reconsideration or for seeking a director's determination as provided below shall result in acceptance of the payer's position.

(13) Payment or disposition of a request for reconsideration shall be issued within 30 days of payer's receipt of the request for reconsideration. Failure to comply with the established deadline shall result in the payer accepting the provider's position asserted in the request for reconsideration.

[11.4.7.8 NMAC - Rp, 11.4.7.8 NMAC, 12-31-13; A, 10-1-15; A, 9-30-16]

11.4.7.9 FEES FOR HEALTH CARE SERVICES

A. Health care provider fee schedule

(1) The director shall issue an order pursuant to Section 52-4-5 NMSA 1978 not less than once per annum setting the health care provider fee schedule which shall list the maximum amount of reimbursement for, or the method for determining the maximum amount of reimbursement for medical services, treatments, devices, apparatus, and medicine.

(2) In addition to the fee schedule, the order shall contain a brief description of the technique used for derivation of the fee schedule and a reasonable identification of the data upon which the fee schedule was based.

(3) The health care provider fee schedule is procedure-specific and provider-neutral. Any code listed in the edition of the current procedural terminology adopted in the director's annual order may be used to designate the services rendered by any qualified provider within the parameters set by that provider's licensing regulatory agencies combined with applicable state laws, rules, and regulations.

(4) The fee schedule shall be released to the public not less than 30 days prior to the date upon which it is adopted and public comments will be accepted during the 30 days immediately following release.

(5) After consideration of the public comments the director shall issue a final order adopting a fee schedule, which shall state the date upon which it is effective. The final fee schedule order shall be available at the WCA clerk's office not less than 20 days prior to its effective date.

B. Hospital ratio

(1) All hospitals shall be reimbursed at the hospital ratio set forth in the health care provider fee schedule. A new hospital shall be assigned a ratio of sixty seven percent.

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

(3) 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.

(4) By February 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.

(5) Appeal of assigned ratio by hospitals. A written appeal 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.

C. Prescription medicine

(1) The maximum payment that a pharmacy or authorized HCP is allowed to receive for any prescription medicine shall be determined by the method set forth in health care provider fee schedule.

(2) Pharmacies shall not dispense more than a 30 day supply of medication unless authorized by the payer.

(3) Only generic equivalent medications shall be dispensed unless a generic does not exist and unless specifically ordered by the HCP.

(4) Compounded medication shall be paid in accordance with the fee schedule.

(5) Any 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.

(6) Health care provider dispensed medications shall not exceed a 10 day supply for new prescriptions only. The payment for health care provider dispensed medications shall not exceed the cost of a generic equivalent.

D. Medical cannabis reimbursement

(1) General Provisions

(a) The maximum payment that a worker may be reimbursed for medical cannabis shall be determined by the method and amount set forth in health care provider fee schedule.

(b) Medical cannabis may be a reasonable and necessary medical treatment only where an authorized health care provider certifies that other treatment methods have failed.

(c) At least one physician certifying worker for participation in the cannabis program shall be an authorized health care provider.

(d) The worker must be an enrolled in the cannabis program and provide proof of enrollment and qualifying condition prior to the date of purchase of medical cannabis to be eligible for reimbursement.

(2) Worker shall be reimbursed upon the following conditions:

(a) Only the worker shall be reimbursed for the out of pocket cost of medical cannabis;

(b) Worker shall submit an itemized receipt issued by a licensed producer that includes the name and address of the licensed producer and the worker, the date of purchase, the quantity in grams of dry weight, the form of medical cannabis purchased, and the purchase price;

(c) Worker shall be reimbursed no more than the maximum amount set forth in the fee schedule;

(d) Reimbursement shall be limited to the quantity set forth in the fee schedule;

(e) Reimbursement for paraphernalia, as defined in the Controlled Substances Act, shall not be made; and

(f) Reimbursement is not allowed for expenses related to personal production or cannabis acquired from sources other than a licensed producer.

E. Referrals

(1) If a referral is made within the initial 60 day care period as identified by Section 52-1-49(B) NMSA 1978, the period is not enlarged by the referral.

(2) When referring the care of a patient to another provider, the referring provider shall submit pertinent medical records for that patient, including imaging, upon request of the referral provider, at no charge to the patient, referral provider or payer.

(3) When transferring the care of a patient to another provider, the transferring provider shall submit complete medical records, including imaging, for that patient to the subsequent provider at no charge to the patient, subsequent provider or payer.

F. Independent medical examinations

(1) All IMEs and their fees must be authorized by the claims payer prior to the IME scheduling and service, regardless of which party initiates the request for an IME.

(2) In the event that an IME is authorized and the HCP and claims payer are unable to agree on a fee for the IME, the judge may set the fee or take other action to resolve the fee dispute.

G. Physical impairment ratings

(1) All PIRs and their fees shall be authorized by the claims payer prior to their scheduling and performance regardless of which party initiated the request for a PIR. The PIR is inclusive of any evaluation and management code.

(2) Impairment ratings performed for primary and secondary mental impairments shall be billed pursuant to the annual fee schedule and shall conform to the guidelines, whenever possible, presented in the most current edition of the AMA guides to the evaluation of permanent impairment.

(3) A PIR is frequently performed as an inherent component of an IME. Whenever this occurs, the PIR may not be unbundled from the IME. The HCP may only bill for the IME at the appropriate level.

(4) In the event that a PIR with a specific HCP is ordered by a judge and the HCP and claims payer are unable to agree on a fee for the PIR, the judge may set the fee or take other action to resolve the fee dispute.

[11.4.7.9 NMAC - Rp, 11.4.7.9 NMAC, 12-31-13; A, 10-1-15; A, 9-30-16]

11.4.7.10 QUALIFICATION OF OUT OF STATE HEALTH CARE PROVIDERS

A. An HCP that is not licensed in the state of New Mexico must be approved by the director to qualify as an HCP under the act.

B. No party shall have recourse to the billing and payment dispute resolution provisions of these rules with respect to the services of an HCP who is not licensed in New Mexico or approved by the director.

C. The director's approval may be obtained by submitting an application to the director and proposed order, supported by an original affidavit of the HCP seeking approval. Nothing in this rule shall prevent the director from entering into agreements with any party or HCP to provide for simplified and expeditious qualification of HCPs in individual cases, provided, however, that all such agreements shall be considered public records.

D. The director's approval of a health care provider in a particular case, pursuant to the provisions of Section 52-4-1 NMSA 1978 will be deemed given when an out of state health care provider provides services to that injured worker and the employer/insurer pays for those services. Unless otherwise provided, the approval obtained by this method will not apply to the provision of health care by that provider to any other worker, except by obtaining separate approval as provided in these rules.

[11.4.7.10 NMAC - Rp, 11.4.7.9 NMAC, 12-31-13; A, 10-1-15; A, 9-30-16]

11.4.7.11 BILLING AND PAYMENT DISPUTE RESOLUTION

A. In the event of a billing or payment dispute any party may submit to the medical cost containment bureau a request for director’s determination on the approved form located on the WCA website.

B. The request shall be made in writing within 30 days of the documented receipt date of the payer's disposition, nonpayment of the bill, or denial of a request for reconsideration. A request for director's determination shall consist of a brief explanation of the disputed billing and payment issue(s) and shall be accompanied by a copy of the bill(s) in question, a copy of the payer's explanation, and all supporting documentation necessary to substantiate the performance of the service(s) and the accuracy of the associated charges.

C. Upon receipt of a request, the administration will initially attempt to resolve the dispute informally. If this is unsuccessful, a notice of receipt of request for director's determination shall be issued to both parties along with a copy of the request for director’s determination.

D. Both parties shall have 15 days from the date of the notice of receipt of request for director's determination to present to the director and opposing party any pertinent additional documentation.

E. The director in his discretion may conduct such hearings and receive such evidence as is necessary to make a determination concerning the reasonableness and necessity of the services provided. A final determination shall issue within 45 days of the issuance of the notice of receipt of request for director's determination or the close of the hearing, whichever is later.

F. The director's determination of the billing and payment dispute is final. Any further attempt, directly or indirectly, to charge any party for any disallowed services or to fail to pay within 30 days of documented receipt of the director's determination for such services as may have been found to be due and owing shall be considered a violation of this rule.

G. The director's determination shall not be considered with regard to the compensability of the claim and shall have no legal force or effect beyond the resolution of the billing and payment disputes.

H. Any time frame set forth in 11.4.7.11 NMAC may be waived by the director, in writing, for good cause shown.

I. Nothing in this rule shall prohibit the parties from resolving their billing dispute prior to or following referral to the administration.

[11.4.7.11 NMAC - Rp, 11.4.7.13 NMAC, 12-31-13; A, 10-1-15; A, 9-30-16]

11.4.7.12 INPATIENT ADMISSIONS, CASE MANAGEMENT AND UTILIZATION REVIEW:

A. Basic provisions

(1) All workers and their legal representatives are required to cooperate with the WCA or its contractor, if any, with respect to all reasonable requests for information necessary for any provision of service.

(2) For the purpose of facilitating the provision of services, all employers, insurers, and third party administrators are required to communicate, cooperate and provide information, without charge, to the WCA or its contractor, if any.

(3) The WCA or its contractor, if any, shall report any refusal to cooperate to the director. Failure to provide requested information shall be presumed to be a refusal to cooperate. Any dispute concerning the

reasonableness of any request for information may be submitted, in writing, to the director. The determinations of the director concerning the reasonableness of such requests are final.

(4) In any hearing before the WCA, the worker's refusal to cooperate in any services may be considered by a workers' compensation judge on the issues of reasonableness and necessity of medical charges or reasonableness, necessity, or appropriateness of medical treatment.

(5) The contractor shall avoid conflicts of interest or the appearance of impropriety when performing case management services and utilization review.

(6) Nothing in these rules prohibits an employer from establishing their own system of case management or utilization review at the employer's expense as provided in Section 52-4-3 NMSA 1978.

B. Inpatient admission review

(1) For every inpatient admission the following information shall be provided to the WCA or its contractor at least 48 hours prior to the admission or before the close of the next business day after any emergency admission:

(a) worker's/patient's name;

(b) worker's/patient's social security number;

(c) worker's/patient's employer;

(d) employer's insurance carrier or third party administrator and a statement of whether they have authorized the admission;

(e) date of injury/onset of symptoms;

(f) admitting diagnosis, including primary, secondary, and tertiary, if any;

(g) planned treatment(s) and procedures;

(h) planned date of admission; and

(i) proposed length of stay.

(2) For planned or elective hospital admissions any practitioner ordering the admission of a worker for evaluation or treatment of their injury or occupational disease disablement shall report the admission to the WCA.

(3) For emergency hospital admissions, the hospital shall report the admission to the WCA.

(4) Any practitioner or hospital discharge planner ordering or arranging a transfer of a worker to another facility shall report to the WCA at least 24 hours prior to any transfer all of the information as is required by Paragraph (1) of Subsection B of 11.4.7.12 NMAC.

(5) Throughout the period of time in which inpatient services are being provided, the WCA shall monitor the worker's treatment regime, including treatments, procedures, and length of stay.

(6) If a hospital or practitioner reports that an employer's insurance carrier or third party administrator has not authorized the admission, the WCA shall issue a recommendation concerning the medical necessity and appropriateness of the admission service and the assigned length of stay before the close of the next business day after the report is submitted to the WCA.

C. Case management and utilization review

(1) Referral process

(a) Any party may refer a claim to the WCA for case management or utilization review by the WCA or its contractor, if any, by submitting the appropriate form to the WCA medical cost containment bureau. The form is located on the agency website.

(b) A WCA judge may refer a claim for case management or utilization review by submitting a written referral to the medical cost containment bureau and with a copy placed in the court file.

(c) Within 20 days of receiving a referral and all supporting documentation, the medical cost containment bureau shall notify the parties and the judge, if any, of its decision either accepting or denying the referral. The medical cost containment bureau may assign approved cases to the WCA's contractor.

(d) Any party who objects to the decision of the medical cost containment bureau shall notify the WCA of its objection by filing an application to the director not later than 15 days from service of the decision.

(2) Case Management

(a) The WCA will consider the following factors when determining eligibility of a case referred for case management:

(i) severe or complex injury including total loss of limb/amputation, severe injury to multiple body parts or limbs, severe burns over a large part of body, traumatic brain injury, spinal cord injury, reflex sympathetic dystrophy/complex region pain syndrome;

(ii) language barrier, including hearing impairment;

(iii) a record or pattern of non-compliance with prescribed treatment, care plan or medical appointments;

(iv) multiple health care providers, including providers of different disciplines, requiring coordination between them;

(v) inpatient admission lasting longer than five days or multiple admissions or emergency room visits;

(vi) failure to reach maximum medical improvement after one year from the date of injury;

(vii) psychological issues that complicate provision of services; and

(viii) any other reasonable criteria as approved by the director.

(b) The WCA will monitor case management services to ensure progress pursuant to Section 52-4-3 NMSA 1978. The WCA may terminate or reassign services as it deems appropriate with notice to the parties.

(c) The contractor shall have the right to contact the worker, insurer, third party administrator, legal representatives, and all HCPs involved in the case. The contractor shall give reasonable notice and an opportunity to the worker or his or her representative to be present during, or to participate in, any and all contacts by the case manager.

(d) The contractor providing case management services may help coordinate services by bringing treatment options or return to work opportunities to the attention of the health care provider.

(e) The contractor shall provide status reports to the WCA as directed, with copies to the parties identified in the initial assignment.

(3) Utilization review

(a) Utilization review shall consider only the medical reasonableness, clinical necessity, efficiency and quality of the treatment under review.

(b) Utilization review shall not include issues of compensability, including:

(i) the causal relationship between the treatment under review and the worker's work-related injury;

(ii) whether the worker is disabled; and

(iii) whether the worker is at maximum medical improvement.

(c) If the medical cost containment bureau or its contractor requests additional information, the parties shall provide the requested information within 15 days. The WCA shall issue its utilization review decision within 60 days of receiving all necessary documentation.

(d) The WCA in its sole discretion may assign a claim to its contractor for peer review. Peer review shall only be conducted by a licensed healthcare provider who is in a similar field or equivalent discipline as the provider whose service is being reviewed. Peer review shall be independent and the physician or health care provider should not have prior involvement in the worker's care or treatment.

(e) The medical cost containment bureau shall communicate the utilization review findings in writing with a copy to all parties. The WCA may adopt the findings of its contractor after utilization review.

(f) Any party who objects to the utilization review findings shall file an application to director within 15 days from service of the utilization review findings. If an application is not filed within 15 days, the utilization review findings shall become binding on the parties.

(g) The director may set a utilization review matter for hearing. An order issued by the director after hearing or receipt of an application to director is final and binding on the parties.

[11.4.7.12 NMAC - Rp, 11.4.7.14 NMAC, 12-31-13; A, 10-1-15; A, 9-30-16]

11.4.7.13 NON-CLINICAL SERVICES

A. A practitioner 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 for copying medical records and reports, except as provided in Paragraphs (10), (11), (12) and (13) of 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 fee of any kind.

B. A practitioner may charge for the completion of the form letter to health care provider the amount set forth in the fee schedule.

C. Depositions

(1) An HCP may not charge more than four hundred dollars ($400) for the first hour or any portion thereof; and not more than three hundred sixty dollars per hour ($360/hour) for the second and subsequent

hours, prorated in five minute increments. An HCP may not charge more than two hundred dollars ($200) for the first hour of deposition preparation time actually spent, and not more than one hundred and twenty dollars ($120) per hour for the second or third hours, prorated in five minute increments, up to a maximum of three hours.

(2) No compensation shall be paid for travel time to or from the deposition, waiting time prior to the scheduled beginning of the deposition, or time spent reading or correcting depositions. For good cause shown, a judge may enter a written order providing recompense to an HCP for reading and correcting a deposition.

(3) An HCP may require that they be paid for the first hour of the deposition testimony either before or at the time of the deposition.

(4) A non-refundable fee of up to four hundred dollars ($400) may be charged by an HCP for deposition appointments at which the attorney making the appointment is a no-show or fails to cancel at least 48 hours in advance.

(5) Any notice of deposition to a practitioner shall contain the following language: "The rules of the WCA provide a schedule of maximum permissible fees for deposition testimony. No more than $400 for the first hour and $360 for each subsequent hour is permitted. Fees for the second and subsequent hours shall be prorated in five minute increments. An HCP may not charge more than $200 for the first hour of deposition preparation time actually spent, and not more than $120 for the second or third hours, prorated in five minute increments, up to a maximum of three hours."

D. Live testimony by a health care provider: Such testimony is allowed only pursuant to an order by a judge. Fees for live testimony, travel, lodging, and preparation time shall be set by the judge.

E. Disputes concerning the non-clinical fee schedule shall be raised with the assigned judge, if any, or pursuant to the medical billing dispute process set forth in 11.4.7.11 NMAC.

[11.4.7.13 NMAC - Rp, 11.4.7.15 NMAC, 12-31-13; A, 10-1-15; A, 9-30-16]

11.4.7.14 ENFORCEMENT: Any complaint of a violation of these rules shall be made, in writing, to the medical cost containment bureau, enforcement bureau, or assigned workers' compensation judge, if any.

[11.4.7.14 NMAC - Rp, 11.4.7.16 NMAC, 12-31-13; A, 10-1-15]

11.4.7.15 DATA ACQUISITION:

A. The insurer must report an inpatient hospital bill to the WCA within 10 to 90 days of payment of the bill. Reports may be submitted by mail, fax, or electronic media in batches daily, weekly, or monthly from the insurer or insurer's representative.

B. The paid inpatient services data shall be submitted in a format acceptable to the WCA. The economic research bureau shall distribute a specific set of instructions for the submission of required data.

If the required paid inpatient services data is not received from payer as stated under Subsection A of this section, the economic research bureau may petition for a hearing before the WCA director and seek penalties pursuant to Section 52-1-61 NMSA 1978.

[11.4.7.15 NMAC - Rp, 11.4.7.17 NMAC, 12-31-13; A, 10-1-15; A, 9-30-16]

HISTORY OF 11.4.7 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center.

WCD 90-1, Nonprofessional Fees Schedule, filed 10-15-90.

WCA 91-6, Nonprofessional Fees Schedule, filed 5-29-91.

WCA 92.6, Rules Governing Fees for Non-Clinical Services, filed 10-30-92.

WCA 91-7, Hospital Fee Schedule, filed 4-1-91.

WCA 91-7, Hospital Fee Schedule, filed 7-15-91.

WCA 92.7, Rules Governing Hospital and Ambulatory Surgical Center Fees, filed 10-30-92.

WCA 93.7, Rules Governing Hospital Inpatient Stays, Outpatient Surgeries, Emergency Department Visits and Ambulatory Surgical Center Fees, filed 3-3-94.

WCA 92-8, Workers' Compensation Administration Rules Governing Utilization Review, Peer Review and Case Management, filed 2-24-92.

WCA 92.8, Rules Governing Utilization Review, Peer Review and Case Management, filed 10-30-92.

WCA 93-8, Rules Governing Utilization Review, Peer Review and Case Management, filed 10-28-93.

WCD 91-9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 12-30-91.

WCA 92.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 11-18-92.

WCA 92.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 12-21-92.
WCA 93.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 2-23-94.
WCA 95.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 11-18-94.
WCA 95.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 1-17-95.

History of Repealed Material:
11.4.7 NMAC, Payments for Health Care Services, filed 12-15-2011 - Repealed effective 12-31-2013.