

This is an amendment to 11.4.7 NMAC, Sections 8 and 13 effective 11/7/2025

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 HCP fee schedule for any health care service as set forth in these rules.

(4) These rules and the director's HCP fee schedule order adopting the HCP fee schedule utilize the edition of the current procedural terminology referenced in the director's HCP fee schedule 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 HCP fee schedule 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) 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.

(4) 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).

(5) Pre-authorization, as outlined in (a) through (f) above, must be obtained by the HCP before services or equipment are provided or the payer will not be held liable for payment of the service or equipment provided.

(6) If an authorization, a pre-authorization or a 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 and the payer shall document all attempts to obtain authorization from the date of the initial request.

C. Billing provision ground rules.

(1) Billing shall be made in accordance with HCP fee schedule issued by the director in conjunction with the director's HCP fee schedule 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 60 days from the date on which services were rendered. Initial billing of inpatient services shall be issued no later than 60 days from the date of discharge.

(6) A HCP's documented, good faith effort to bill within the time-limits provided by these rules shall not constitute untimely filing.

(7) Failure of the provider to submit billing, or to demonstrate a good faith effort to submit billing, within the time limits provided by these rules shall constitute a violation of these rules and shall absolve the employer of financial responsibility for the bill.

(8) 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 HCP 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 (12) 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.

(9) 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.

(10) 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.

(11) 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.

(12) 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.

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

(14) 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.

(15) 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.

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

(17) 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) 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 Subsection A of Section 52-1-49 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/insurer who subcontracts bill review services remains fully responsible for timely payment of reasonable and necessary services along with compliance with these rules.

(6) Fees and payments for all physician professional services, regardless of where those services are provided, are reimbursed within the HCP 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[-];
- (f) any other authorized EOB referenced in the HCP fee schedule.

(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 the HCP fee schedule 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, including corrected claims, shall be submitted to the payer within 30 days of receipt of the payer's written 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, 1/1/2023; A, 11/7/2025]

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11.4.7.13 NON-CLINICAL SERVICES

A. For medical records and report copies requested for the purpose of investigating or administering a workers' compensation claim, a practitioner may charge for paper and electronic copies as set forth in the HCP fee schedule, except as provided in Paragraphs (12), (13), (14) and (15) 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 WCA Form Letter to Health Care Provider the amount set forth in the HCP fee schedule.

C. A practitioner may charge for the completion of the WCA Provider's Report of Physical Ability according to the criteria and amount set forth in the HCP fee schedule.

D. Depositions

(1) An HCP may not charge more than [~~\$400 for the first~~] \$800 per hour [~~or any portion thereof, and not more than \$360 per hour for the second and subsequent hours~~], prorated in [~~five~~] 15-minute

increments. An HCP may not charge more than [~~\$200 for the first~~] \$400 per hour of deposition preparation time actually spent, [~~and not more than \$120 per hour for the second or third hours,~~] prorated in [~~five~~] 15-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 [~~\$400~~] \$800 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~~] HCP 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~~] \$800 per hour [~~and \$360 for each subsequent hour~~] is permitted, prorated in 15-minute increments. [~~Fees for the second and subsequent hours shall be prorated in five minute increments.~~] An HCP may not charge more than [~~\$200~~]-\$400 for the first hour of deposition preparation time actually spent, [~~and not more than \$120 for the second or third hours,~~] prorated in [~~five~~] 15-minute increments, up to a maximum of three hours."

E. 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.

F. Disputes concerning the HCP 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, 11.4.7.13 NMAC, 1/1/2023; A, 11/7/2025]