



Health Care Provider 's Guide to New Mexico Workers ' Compensation

New Mexico Workers ' Compensation Administration



THE HEALTH CARE PROVIDER'S GUIDE TO NEW MEXICO WORKERS' COMPENSATION

INTRODUCTION	3
Numerical References to Statute and Rules.....	3
Your comments on this publication.....	3
Update for the 2008 Edition	4
SECTION 1. Treating a patient under workers' compensation -- what's different?.....	5
The role of the New Mexico Workers' Compensation Administration.....	6
Director's Medical Advisory Committee (§52-4-5(F)).....	6
WCA Publications	7
WCA Ombudsman Program	7
WCA Medical Cost Containment Bureau.....	7
To obtain copies of the WCA Rules and Medical Fee Schedule	7
Definition of health care provider.....	8
SECTION 2. Who is responsible for covering this claim and paying your bill?.....	9
Has your patient notified his employer of his accident or injury?.....	10
What happens if the claim is denied?.....	11
SECTION 3. Health care provider choice -- who selected you to treat this patient? (§52-1-49 and NMAC 11.4.4.11)	12
Emergency care.....	12
Referrals from the emergency room.....	13
All non-emergency care.....	13
Health care provider selection and change chart	14
How health care provider selection works	15
Out-of-state providers (NMAC 11.4.7.9.I).....	17
Patient's rights regarding travel costs (NMAC 11.4.3.11).....	18
SECTION 4. Medical decisions in workers' compensation.....	19
Was this a work-related injury or occupational disease?	19
Mental or emotional effects of injury; mental impairment.....	20
Other conditions governed by specific provisions of law	21
Right to lifetime medical treatment (§52-1-49, §52-5-12, §52-5-13).....	22
Pharmacy benefits (NMAC 11.4.7.9(H)).....	22
Payments to hospitals and ambulatory surgical centers (§52-4-5-(G))	23
SECTION 5. Can this worker go back to work?	24
Documenting Return to Work.....	25
Rights of your patient regarding employment and rehire	25
Communicating with the employer.....	26
Maximum medical improvement -- what it is, and what it means for the patient (§52-1-24.1).....	26

Calculating impairment ratings	28
Two ways to figure impairment: scheduled injury or whole body	28
Treatment, referrals and pre-approvals	30
SECTION 6. Billing and payment	33
How much will I be paid for my services (§52-4-5)?	34
Billing and payment disputes (NMAC 11.4.7.13)	36
SECTION 7. Utilization Review and Case Management	37
Utilization review (§52-4-2).....	37
Case management (§52-4-3)	37
SECTION 8. Your role in disputes between the worker and the employer/insurer	38
How disputes are handled in New Mexico workers' compensation	38
Independent Medical Examinations	39
Glossary of Terms	40
APPENDIX 1: Bureaus and functions of the WCA of interest to health care providers	45
Advisory bodies.....	45
WCA bureaus.....	45
APPENDIX 2: The Schedule of Injuries to Specific Body Members (§52-1-43)	47
APPENDIX 3: Form Letter to Health Care Providers	48
APPENDIX 4. WCA Approved Patient's Medical Release Form (English)	52
APPENDIX 5. WCA Approved Patient's Medical Release Form (Spanish)	54
APPENDIX 6. Optional forms	56
for the Emergency Room and Physician's Office	56
Primary Care Physician Offices	58
Checklist for first visit to primary care physician	58
under New Mexico workers' compensation	58
APPENDIX 7. Demand for Notice of Contested Billing, Form and Instructions	63

INTRODUCTION

This book was written for health care professionals and administrators, especially those who treat patients under the New Mexico workers' compensation system but do not specialize in occupational health. This book is addressed to doctors, medical administrative staff, and other providers such as physical therapists.

The purposes of this guidebook:

- to encourage and facilitate your participation in assisting injured workers,
- to give you a general overview of the system,
- to make the system easier to understand,
- to help you understand the effects of your actions and decisions on your patient, and
- to enable you to give useful information and guidance to your patient.

This book does not attempt to duplicate the details of the Rules of the WCA that pertain to you -- Rules such as those governing billing and payment issues, the parties' right to change of health care provider, etc. You may need a current set of the Rules and a current edition of the WCA's medical fee schedule, currently called the Physicians' Fee Schedule (PFS), formerly known as the Schedule of Maximum Allowable Payments or MAP.

If you have received this book without the fee schedule and the Rules, or, if you need to update these materials, please see page 7 for the instructions about how to obtain copies.

Numerical References to Statute and Rules

Throughout this book you will see numerical citations in parentheses. These citations are paragraph numbers in the New Mexico statutes or the Rules of the WCA. You may find these citations helpful if you have to research an issue.

A number in parentheses beginning with "§52" refers to a paragraph of the workers' compensation statute, Chapter 52 of the New Mexico Statutes.

A number beginning with NMAC refers to the Rules of the WCA, filed under the New Mexico Administrative Code.

Your comments on this publication

Comments on this publication will be welcome. Please send your comments to Merilee Dannemann. Call 841-6074, or 1-800-255-7965 toll free (in state only); write to Workers' Compensation Administration, PO Box 27198, Albuquerque, NM 87125 or e-mail Merilee.Dannemann@state.nm.us.

Update for the 2008 Edition

The 2008 update contains a few changes from the previous edition. For simplicity, these changes are listed here.

- The name of the WCA medical fee schedule is changed from MAP to Physicians' Fee Schedule (PFS).
- The fee schedule is now accessible online.
- The rules have been changed regarding billing for hospitals and ambulatory surgical centers. For specific information on the changes, go directly to the WCA Rules Part 7.
- A chart diagramming the health care provider selection process has been added to the narrative text.
- The former Director's Policy Directive on communication between the physician and the employer/insurer is deleted.

SECTION 1. Treating a patient under workers' compensation -- what's different?

When you treat a patient under the workers' compensation system, you are not just responsible for guiding that patient's recovery. You also have a valuable role in providing information for, and determining the outcome of, that patient's workers' compensation claim and future employment status.

This book provides information about the special rules of the workers' compensation system that affect your treatment of this patient. If you are the treating physician, you may be expected to:

- Be subject to the health care provider choice system. If you are the primary treating provider, either you will be the doctor selected by the patient or you will be selected by the employer/insurer. This selection will be subject to change.
- Give a medical opinion as to whether the worker's condition was caused by a work-related accident or occupational disease.
- Provide medical guidance about when the patient can go back to work and work restrictions, if any.
- Determine when the patient has reached maximum medical improvement.
- Evaluate the patient for an impairment rating according to the *AMA Guides*.
- Provide documentation required for payment of bills, including medical notes explaining your treatment.
- Receive payment according to the New Mexico Workers' Compensation Administration medical fee schedule (PFS).
- Comply with utilization review requirements / obtaining approvals for covered treatments.
- Cooperate with WCA-appointed case managers when required.
- If there is a legal dispute about the case, give a deposition if required.

This guidebook discusses all of these subjects.

The role of the New Mexico Workers' Compensation Administration

The WCA is a state agency with three areas of responsibility:

- to educate and assist all parties in the workers' compensation system;
- to regulate many facets of the workers' compensation system, including medical costs;
- to resolve disputes between injured workers and their employers/insurers.

Medical-related activities of the WCA include:

- a medical fee schedule (Physicians' Fee Schedule or PFS), which is reviewed and updated annually (§52-4-5);
- a separate schedule for hospital charges (§52-4-5 (G));
- methods for resolving billing and payment disputes (§52-4-5(E));
- a utilization review program (§52-4-2);
- a case management program (§52-4-3);
- a special type of hearing to resolve disagreements between the patient and the employer/insurer about the selection of health care provider (§52-1-49).

These activities are discussed in more detail later in this booklet.

Director's Medical Advisory Committee (§52-4-5(F))

The law provides two formal methods for the health care community to provide information and feedback to the WCA concerning rules, medical fees, and other matters.

The Director's Medical Advisory Committee is established in law. The committee serves at the request of the Director, who appoints the members. While the law does not specify the number of members, it does say that the majority of members shall represent health care providers and that the committee shall reflect the diversity of the types of practitioners who may be authorized providers under the workers' compensation law.

If you are interested in staying informed about this committee, or in volunteering to serve, contact the Medical Cost Containment Bureau through the main telephone number.

Rules hearings are formal events at which the public is given opportunity to comment on proposed changes to rules, fee schedules and the like. The procedure for adoption of rules, including public hearings, is governed by the same laws throughout New Mexico government. When changes to the rules are being considered, draft rules are published, the public is given an opportunity to review the draft and interested persons are invited to comment either in person at a hearing or through written comments.

Professional associations representing health care professions sometimes participate in rules review processes, some more actively than others. Any individual is free to participate.

If you are interested in staying informed about upcoming rulemakings, changes to the medical fee schedule and the like, you can have your name placed on a notification list. Contact the office of the General Counsel through the state headquarters main telephone number.

WCA Publications

The WCA publishes a number of books and booklets to help injured workers and their employers. These books -- all available free of charge -- may be of value to you or your patient. Please see the WCA web site at www.workerscomp.state.nm.us for a current list of publications and how to obtain copies. Most of the publications are available online and may be downloaded and printed at your convenience.

WCA Ombudsman Program

The WCA has a staff of ombudsmen, workers' compensation claims specialists who are available in person or by telephone during business hours. Anyone can call an ombudsman with any question about workers' compensation claims. The ombudsmen are on staff at all WCA offices; some are Spanish-speaking.

Throughout this book you will see references to the ombudsman program. You or your patient may call an ombudsman with any question related to the claim, unless your patient is represented by an attorney.

WCA Medical Cost Containment Bureau

The Medical Cost Containment Bureau administers the WCA utilization review and case management programs and assists in the resolution of billing and payment disputes. You can call this bureau with questions about the medical fee schedule, billing and payment issues and similar matters.

To obtain copies of the WCA Rules and Medical Fee Schedule

Beginning in 2008, the WCA's medical fee schedule is available online in an abbreviated form.

The fee schedule, formerly known as the Schedule of Maximum Allowable Payments, is now called the Physicians' Fee Schedule or PFS.

You can download a copy from the WCA web site at www.workerscomp.state.nm.us. You must register for the download and agree to copyright restrictions based on the WCA's agreement with the American Medical Association.

(NOTE: the 2008 fee schedule actually has an effective date of December 31, 2007.)

The Rules of the WCA can be downloaded also. For rules related to health care issues, including billing and payment, look for Rules Part 7.

You can also obtain these materials in print by picking them up in person from any office of the WCA. See the complete list of offices and phone numbers at the end of this book.

To obtain printed copies by mail, you will be asked to provide a self-addressed stamped envelope with correct postage. Call the WCA reception office for the current correct postage.

If you send a self-addressed stamped envelope, write a note stating exactly what you want; include a phone number and the name of the contact person at your office. Mail this to:

New Mexico Workers' Compensation Administration
PO Box 27198
Albuquerque, NM 87125-7198

Older editions of the medical rules are called the Schedule of Maximum Allowable Payments, or MAP, and are available only in print. Call any office of the WCA for assistance.

You can also obtain these materials in person at the WCA state headquarters in Albuquerque or at any WCA field office. See the complete list of offices at the end of this book.

Definition of health care provider

The workers' compensation law gives the status of health care provider to New Mexico-licensed practitioners in all the following professions: physician (MD), osteopathic physician (DO), chiropractor (DC), dentist, optometrist, podiatrist, physician assistant, certified nurse practitioner, physical therapist, occupational therapist, doctor of Oriental medicine, psychologist, certified nurse-midwife, hospital, and any other person or facility that provides health-related services in the health care industry, as approved by the Director of the WCA (§52-4-1).

Not all health care providers have the same standing under law. For example, an impairment rating can be given only by an MD, DO or DC. (§52-1-24.1 and §52.4.1; NMAC 11.4.7.7.JJ).

SECTION 2. Who is responsible for covering this claim and paying your bill?

The payer of medical bills under workers' compensation is the insurer or self-insurance program for the patient's employer. The types of payers are described below.

One way to find out the name of the payer is to ask the patient to look at the workers' compensation poster posted at work. There is a blank section in the middle of the poster, which the employer should have filled in with the name and contact information for the responsible party.

If your patient cannot get the necessary information from the employer, you may choose to call the employer. If there is a problem, you can contact an ombudsman at the WCA or recommend that the patient do so.

Private employers

If this is a workers' compensation covered claim for a private employer, you should be paid by:

- an insurance company or
- a self-insurance program or
- a "third party administrator," a professional claims adjusting firm.

More than half of private sector employees are covered by insurance companies. By law, every insurance company must have a New Mexico licensed adjuster. You should be able to obtain a New Mexico address and telephone number. If you are given only an out-of-state telephone number, the insurer may be in violation of New Mexico law.

Individual self-insurance programs cover certain large employers. These programs are certified and regulated by the Workers' Compensation Administration. They may pay claims directly or use a third party administrator.

Some businesses are covered by group self-insurance programs through their trade associations (Statute Chapter 52, Article 6). These programs must be certified by the Workers' Compensation Administration. These programs handle claims themselves or through a New Mexico third party administrator.

State, local government, public school employees

If the patient is employed by a state agency, local government agency, public school district or public higher education institution, the payer will be a governmental pool or individual self-insurance program.

Public school employees in most of the state's districts are covered by the Public Schools Insurance Authority, which contracts with a third party administrator to pay its claims.

Governmental pools also cover most of the state's cities and counties. A few of the largest cities, counties and school districts have chosen to be individually self-insured. State government employees and employees of some government subdivisions are covered by the Risk Management Division of the New Mexico General Services Department.

Federal government employees

Federal employees are not covered by New Mexico workers' compensation. There is a separate federal workers' compensation program to cover federal employees. This program has separate rules and procedures. The New Mexico Workers' Compensation Administration has no jurisdiction over federal workers' compensation claims. The information in this book does not apply to the federal workers' compensation program.

Tribal employees and tribal members

Some Native American tribes within New Mexico have chosen to have New Mexico workers' compensation coverage for their tribal enterprises. Other tribes have chosen to require private businesses located on their land to provide New Mexico workers' compensation coverage.

If a tribal employee is covered by a New Mexico workers' compensation insurance policy, the claim will generally be handled in the same manner as any other New Mexico claim.

Some tribes have developed their own separate systems, which are separate from New Mexico law and not covered by this book.

Uninsured worker (§52-1-9.1)

If your patient worked for an employer who was required by New Mexico to have workers' compensation insurance but did not have the coverage, your patient might be eligible for benefits through the New Mexico Uninsured Employers' Fund. If the patient qualifies, the fund will pay the medical and indemnity benefits and then seek reimbursement from the uninsured employer, with substantial penalties.

The Uninsured Employers' Fund is administered by the WCA. If you have such a patient, have the patient contact an ombudsman at the WCA to apply to the fund.

Has your patient notified his employer of his accident or injury?

For a workers' compensation claim to be established, the worker must notify the employer or a supervisor that an accident has occurred (§52-1-29) so the employer can notify the insurer or self-insurance program. This is not required if the employer had direct knowledge of the accident, such as someone in management witnessing the accident.

(Employers should have copies of a standard form called a Notice of Accident form posted where employees have access to them.)

This seems like an obvious first step. However, if your patient claims to have a work-related injury and nobody in management seems to know about it, ask the patient whether this has been done. If your patient doesn't know what to do, you may wish to recommend that he call an ombudsman.

What happens if the claim is denied?

The insurer or self-insurance program has a right to deny the claim if it appears that it is not based on a legitimate work-related accident, or for certain other reasons. If that happens, the workers' compensation insurer or self-insurance program may refuse to pay your bill.

If the patient believes he has a legitimate claim, the denial is not the end of the road, or the end of the process. However, it does mean that your bill will probably not be paid promptly.

The patient can pursue the workers' compensation claim by filing a complaint with the WCA. The first step would be for the patient to contact an ombudsman at the WCA. This generates a legal process to determine whether the claim was legitimate. If it was, your bill should be covered.

If the patient decides not to pursue the claim, and has other health insurance, then the health insurance can be billed.

SECTION 3. Health care provider choice -- who selected you to treat this patient? (§52-1-49 and NMAC 11.4.4.11)

Who selected you to treat this patient -- the patient or the employer?

The New Mexico workers' compensation law creates a unique system of health care provider selection. This system applies to all health care delivered under workers' compensation in New Mexico except emergency care.

Under this law, one party (worker or employer/insurer) selects the health care provider who provides the initial (post-emergency) treatment. The employer decides which party selects first. The party who did not select the first provider has the right to change to a different provider after the patient has been under treatment by the first provider for 60 days. If a change is made, the second provider will usually be the authorized treating provider for the rest of the duration of the case, no matter how long.

Usually the health care provider choice issue will not concern you. If a problem arises, this section provides basic information. **Issues related to health care provider selection are matters for your patient and the employer/insurer, not you or your staff.** If the patient needs help, the ombudsman staff at the WCA can assist with details about procedures for changing health care providers or responding to notification about changes in health care provider. The patient may call 1-866-WORKOMP (1-866-967-5667) or the nearest WCA office. See list of offices and phone numbers at the back of this book.

You are welcome to call an ombudsman if you need information. You may also wish to refer to the WCA's *Workbook for Injured Workers* or Booklet B4 of the WCA booklet series *The Workers' Compensation Handbook for New Mexico*, "Health Care Issues in Workers' Compensation." Booklet B4 is available in print or can be downloaded from the WCA web site at www.workerscomp.state.nm.us.

Emergency care

For the emergency room and any emergency provider

The following section on health care provider choice does not apply to emergency care. In an emergency, you can treat an injured worker without regard to the selection rules. As long as the treatment is the result of a work-related accident, you should be covered for payment.

Referrals from the emergency room

Emergency providers normally give the patient a referral for follow-up care, and often make an appointment with a specific provider.

These instructions frequently cause problems later for the patient because they may conflict with the health care provider selection process. To reduce this problem, the WCA suggests:

When giving the recommendation for follow-up care, advise the patient to check with his employer before keeping the appointment, as the employer may want the patient to see a different provider; or to call an ombudsman at the WCA before keeping the appointment.

This simple instruction can help prevent injured workers from losing a legal right that may be valuable in the future.

You will probably want to remind the patient that, if his employer gives him an instruction not to go to that particular provider, to call the provider and cancel.

Please see the optional forms in Appendix 6. The Emergency Room form is a one-page flier that may be posted.

All non-emergency care

Under the workers' compensation law, the employer has the right and responsibility to choose whether to select first or second.

Under this system:

Either

- you are the authorized treating health care provider or
- you are treating the patient on a referral from an authorized health care provider.

Either you (or the physician who referred the patient to you)

- have been selected by the worker (patient) or
- have been selected by the employer/insurer.

Either you (or the physician who referred the patient to you)

- have been selected first, or
- have been selected second, or
- have been selected by means of the resolution of a dispute over selection.

A referral from an authorized treating provider to another provider does not constitute a selection.

Health care provider selection and change chart

The information summarized in this chart is explained in the following pages.

<p>1. The employer is responsible for communicating with workers. 2. Employer should provide instructions IN ADVANCE in writing by establishing a policy that applies to all employees. Either the employer tells workers that employer is selecting the health care provider, or the employer tells workers to select their own health care provider. 3. If employer has not provided any instruction in advance, employer should provide an instruction as soon as possible, BEFORE any non-emergency health care.</p>	
<p>IF EMPLOYER SELECTS FIRST Employer instructs worker to use a specific health care provider.</p>	<p>IF WORKER SELECTS FIRST Employer instructs worker to select a health care provider of the worker's own choosing.</p>
<p>Worker must be treated by this health care provider (and other providers referred by the treating provider) for 60 days.</p>	<p>Worker will be treated by this health care provider (and other providers referred by the treating provider) for 60 days.</p>
<p>SECOND SELECTION BY WORKER 4. After the initial 60-day period, the worker will have the right to change to a different health care provider. Worker sends Notice of Change of Health Care Provider to claim representative. The Notice may be sent on Day 50 or later.</p>	<p>SECOND SELECTION BY CLAIM REPRESENTATIVE 4. After the initial 60-day period, the claim representative will have the right to require the worker to change to a different health care provider. Claim representative sends Notice of Change of Health Care Provider to worker. The Notice may be sent on Day 50 or later.</p>
<p>5. Ten days after filing the notice, if the claim representative has not objected, the worker may start treatment with the new health care provider. The new provider will be the authorized treating provider for the rest of the claim.</p>	<p>5. Ten days after receiving the notice, if the worker has not objected, the worker must make an appointment with the new health care provider. The new provider will be the authorized treating provider for the rest of the claim. The claim representative will not pay medical bills for further treatment by first provider.</p>
<p>IF THERE IS AN OBJECTION TO THE CHANGE The right to change is automatic. The party who objects has the burden of proof to show that the change will result in medical care that is not reasonable or that the party filing the Notice of Change is not entitled to the Automatic Right to Second Selection.</p>	
<p>6. If the claim representative wants to object to this change, the claim representative must file objection within 3 days of receiving the Notice of Change. A hearing before a workers' compensation judge will be scheduled and held within 7 days of the filing of the objection.</p>	<p>6. If the worker wants to object to this change, the worker must file objection within 3 days of receiving the Notice of Change. A hearing before a workers' compensation judge will be scheduled and held within 7 days of the filing of the objection.</p>

How health care provider selection works

First selection

The employer has the right and responsibility to decide whether the employer or worker will make the first selection of health care provider. The employer is responsible for informing the worker of this decision. Under the rules of the WCA (NMAC 11.4.4.11.C (2)), employers are required to instruct all their employees in advance, as a company policy. In reality, employers often do not do this.

If the employer has not provided instructions in advance, the employer may be considered to have made the first selection, though this is subject to dispute. If the employer has selected first, the injured worker will have the right to make the second selection.

Normally, the worker must be treated by the first health care provider for 60 days before a change can be made under the automatic right to change. The 60-day period begins with the date of the first treatment or visit (NMAC 11.4.4.11.E(1)).

Second selection

There are two ways that the patient or the employer/insurer may change authorized health care provider in a workers' compensation case:

1. By the automatic right to second selection (§52-1-49(C)).
2. By a "request for change" at any time, with a workers' compensation judge deciding whether to grant the request (§52-1-49(E)).

Automatic right to second selection

The party who did not make the first selection can make a change by notifying the other party in writing, no earlier than the 50th day of treatment. The document is called a Notice of Change of Health Care Provider. The notice must contain certain legally required information, including the name and address of the new doctor (NMAC 11.4.4.11.E (2)). It can be written on an optional form or a letter. The form is available on the WCA web site.

The party who receives the notice must change to the new doctor on the 60th day, or respond with an official disagreement. The disagreement must be sent within three days of receiving the notice. The response should be sent to the other party and the WCA Court Clerk, using a Health Care Provider Disagreement Form. The form is available on the WCA web site.

Disagreement with second selection must be filed within three calendar days of receiving the Notice of Change. If the Notice is received on a Friday, the Disagreement must be filed the following Monday. If a Disagreement is filed, it will result in a hearing before a workers' compensation judge within seven days. Health care providers usually do not participate in this hearing.

If your patient receives such a notice and doesn't understand it, you might recommend that the patient call an ombudsman immediately.

Under the law (§52-1-49), the right of change in this situation is automatic. If a party wants to oppose the change, it is not enough to argue that the current treatment is successful or going well. The party who objects to the change has the burden of proof. This party must be able to show a judge that the proposed change is not reasonable, or that the party claiming the right to change actually made the first selection and therefore has no right to change. The most common reason for a hearing is a disagreement about which party selected the first provider.

If you were treating the patient and a change occurs, your subsequent services will no longer be covered, whether you were the authorized treating physician or treating on referral.

If you are selected by the patient as the second provider under the automatic right to change, there is the possibility of denial of payment by the insurer or self-insurance program based on the standard of "reasonableness and necessity" of care. Occasionally the payer may object to a certain treatment because it has already been tried; or because of the number of treatments proposed. You might find it helpful to obtain the medical records from the previous provider, or to obtain pre-approval from the payer. (See the subsection, "Treatment, referrals and pre-approvals.")

Request for change of provider at any other time

If one party or the other is seriously dissatisfied with the health care being provided, there is another option.

Either the worker or the claims representative can seek to have the health care provider changed by order of a workers' compensation judge, at any time. The party who is requesting the change would have the burden of proof, and would have to be able to demonstrate at a hearing that the current treatment is unreasonable.

The Health Care Provider Disagreement Form must be used. The party who wants to make a change must file this form with the WCA Court Clerk, who will schedule a hearing within seven days.

Question: My patient does not know who selected the first doctor. The patient thinks she is seeing me on instructions from her employer, but she received a Notice of Change form, which states that the employer has the right to require her to change doctors now. What should she do?

Answer: Suggest that the patient contact an ombudsman immediately. It's possible that a miscommunication occurred that will have to be sorted out by a workers' compensation judge in a hearing. If, after talking to an ombudsman, the patient decides to file an objection, the hearing will be scheduled within seven days.

Question: The worker was seeing a doctor selected first by the employer /insurer. The worker wanted to change to be treated by me. However, before 60 days were up, the employer's doctor said the worker was fully recovered and didn't need any more treatment.

I disagree. I think this patient is not fully recovered and I would like to treat her. What should the patient do?

Answer: The patient can file a Notice of Change of Health Care Provider and name you as the new provider. The insurer might allow you to treat, might file an objection so that a hearing will be held, or might deny payment.

If an objection is filed, the hearing will be scheduled within seven days of the filing of the objection. To obtain your medical opinion for this hearing, the patient might have to see you before the hearing and pay the bill for that visit herself.

If there is no communication from the insurer, you or the patient might wish to check with the insurer to be certain of payment.

Question: I am the patient's family doctor -- but I don't take workers' compensation cases. My patient said she was told by her supervisor to "go to your own family doctor." What is the right course of action for me?

Answer: You could refer the patient to another physician or to advise the patient to go back to the employer for a different instruction.

In this situation it is not clear whether, by giving this instruction, the employer has made the first selection or has allowed the patient to make the first selection. The patient should contact an ombudsman.

Examination of the patient you previously treated (§52-1-51(D) as amended by SB45, 2005)

If you were selected first, and the other party then changed to a different doctor, you might be asked to reexamine this patient from time to time. These examinations will be requested by the party who had previously selected you. They will be limited to one every six months, unless more frequent examinations are ordered by a workers' compensation judge. If you need to verify that you will be paid for this examination, contact the claim administrator (pre-approvals are discussed in Section 5).

Out-of-state providers (NMAC 11.4.7.9.I)

If you are located in another state, you can be considered an authorized provider if:

- this is an emergency, or
- you apply to the WCA for approval, or
- the insurer or self-insurance program acknowledges your status by paying your bill; or
- you are licensed in New Mexico as well as the other state.

The approval applies only to the particular patient you are currently treating. The WCA does not provide blanket approval for an out-of-state provider to treat patients.

If you have received any payment from the insurer for this claim, you are assumed to be approved, and the application process is not necessary.

The application materials are available on the WCA web site or through the Office of the General Counsel.

Patient's rights regarding travel costs (NMAC 11.4.3.11)

If the patient has to travel 15 or more miles each way for medical appointments, the insurer or self-insurance program is responsible for paying travel costs.

This is not your responsibility; however, you may wish to remind the patient to make a claim for these expenses. The patient may wish to refer to the WCA publications or call an ombudsman for more information.

SECTION 4. Medical decisions in workers' compensation

If you are the treating provider in a workers' compensation case, your responsibility goes beyond simply treating the patient. You play a major role in the management of your patient's workers' compensation claim, and you may be called upon to offer opinions that will affect the claim and your patient's return to employment.

Was this a work-related injury or occupational disease?

You might be asked to give your medical opinion as to whether the patient's condition was caused by work or aggravated by work.

If the patient's condition is not the result of something that happened at work, it is not covered by workers' compensation, and the insurer or self-insurance program is not financially responsible for paying for it.

This is not likely to be an issue if there was an accident at work that clearly caused the injury.

However, it could be an issue under certain circumstances. For example :

- The injury is a back injury that could have been connected to a specific incident at work but could also have other explanations.
- The injury is a repetitive motion injury that might have been caused by work or by non-work-related activities.
- The condition is not an injury but a disease that could have been caused by environmental factors at work (such as chemical exposure) or by other factors.
- The patient was injured, but there is doubt whether it happened at work or whether the patient fraudulently claimed it happened at work to collect workers' compensation benefits.

It might be beneficial for you to address the issue of causation in your initial report so that the insurer can be sure that this is a covered claim. A simple statement that the condition is result of a work-related accident (if that is your medical opinion) may be sufficient. See Section 6 for more information about medical notes that must accompany bills.

Occupational disease (§52-3-32)

An occupational disease is described in the law as any disease which appears to have had its origin in a risk connected with employment and to have followed from that risk or exposure as a natural consequence.

A dispute could arise over whether a disease originated from a work-related source. If the disease is not work-related, the employer's insurer or self-insurance program is not financially responsible for it.

If the insurer or self-insurance program denies the claim, but the worker still wants to try to obtain benefits, the worker has to file a complaint with the WCA to seek a decision supporting the claim. To prove the claim, the worker will have to obtain expert medical testimony to establish the causal connection as a medical probability.

Mental or emotional effects of injury; mental impairment

1. Mental health services:

A patient who suffered mental or emotional effects from an injury may be entitled to mental health services as part of the treatment. To be covered by workers' compensation, the emotional or mental effects must be the result of this injury.

As with all health care services under the New Mexico workers' compensation law, the patient may continue to receive these services even after the indemnity portion of the claim is closed, if continued treatment is medically necessary.

2. Mental impairment benefits:

A patient who suffered a mental impairment, as described in the workers' compensation law, may be entitled to indemnity benefits because of the mental impairment.

The law specifies two distinct types of mental impairment:

Primary mental impairment (§52-1-24 (B) and §52-1-42) is a mental impairment brought on by a traumatic incident. It is similar to post-traumatic stress. A physical injury is not necessary for primary mental impairment to occur. For example, a cashier who was robbed at gunpoint but was not physically injured herself could be eligible for this benefit.

Secondary mental impairment (§52-1-24 (C) and §52-1-42) is a mental or emotional effect of a physical injury, such as depression. A finding of secondary mental impairment could increase the dollar amount of the benefits due to the worker for the physical injury.

Emotional Stress:

Normal emotional stress, such as that resulting from a high-stress job, personality clashes at work or job discipline, is not covered by New Mexico workers' compensation.

Other conditions governed by specific provisions of law

Hernia (§52-1-45)

A special standard of proof can be applied to hernias if, and only if, the employer had required the worker to be examined for hernia prior to employment.

If this examination was done, the worker may be required to show that the hernia is of recent origin, is work-related, resulted from a sudden, severe strain or force at work, and did not exist prior to the date of the alleged injury.

If there is doubt about whether a hernia is covered by workers' compensation, it might be helpful for you or the patient to call an ombudsman at the Workers' Compensation Administration.

Facial disfigurement (§52-1-44):

For serious permanent disfigurement about the face or head, the law provides an extra cash benefit up to a maximum of \$2,500. This cash benefit does not rule out restorative surgery or other medical procedures to correct disfigurement.

Influence of drugs or alcohol (§52-1-11, §52-1-12, §52-1-12.1)

The law does not require the health care provider to test for drugs or alcohol, nor does it prohibit testing. The issue of whether drug screens will be performed is between the worker and the employer.

If the worker was under the influence of drugs or alcohol at the time of the accident, it could have a substantial effect on the worker's entitlement to benefits. Depending on whether the drug or alcohol involvement caused the accident, the claim could be denied entirely, or the indemnity benefits (benefits paid to the worker) could be reduced.

If the claim is denied entirely, the insurer is not responsible for any costs of the injury. If indemnity benefits are reduced, the insurer retains full responsibility for payment to the health care provider.

Injurious practices (§52-1-51(I))

If a patient hinders his own recovery by injurious practices, or refuses to submit to reasonable medical or surgical treatment, the insurer or self-insurance program could suspend or discontinue benefits upon the order of a workers' compensation judge. In extreme cases the claim could be terminated. In such a case, the patient would have no more right to medical care under the claim.

Right to lifetime medical treatment (§52-1-49, §52-5-12, §52-5-13)

The New Mexico workers' compensation law restricts the use of lump-sum settlements. The law says (§52-5-12): "It is stated policy for the administration of the Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law that it is in the best interest of the injured worker or disabled employee that he receive benefit payments on a periodic basis."

In most circumstances the law prohibits the parties from closing out future medical benefits with a lump sum settlement. That means the injured worker is entitled by law to medical care (limited to the work-related injury) for the rest of his life if necessary. The worker may be entitled to this even if the indemnity portion of the claim has been closed (if the case itself was disputed, and it is resolved by being treated as a "doubtful" claim, future medical benefits may not be available).

Actually getting the insurer or self-insurance program to agree to pay for long-term care may be problematic in some cases, especially if the patient goes for months or years without need for medical care and then develops symptoms requiring care. Since the insurer or self-insurance program is responsible only for this particular injury, the payer may argue that the new need for care could have arisen from a new injury or from complications due to the normal ageing process. It would be prudent to contact the insurer or self-insurance program for authorization if payment or compensability is a concern.

Question: My patient has a condition that might deteriorate with time and require surgery some time in the future. If the patient accepts a lump sum, will that affect his coverage for the surgery?

Answer: In a normal lump sum agreement, the right to payment for the medical care will remain open, but the patient will no longer have a claim for temporary total disability benefits for that future recovery period. If the claim remains open, the patient could seek those benefits. A patient not represented by an attorney should discuss options with an ombudsman before agreeing to a settlement.

Pharmacy benefits (NMAC 11.4.7.9(H))

Where possible, a generic equivalent should be prescribed over brand name medication, unless specifically ordered by a health care provider.

The payer may have a preferred provider of pharmaceuticals, such as a drug store chain or a mail order service. You can help your patient by checking with the claims representative before the patient fills a prescription. If the use of a specific provider would create an obstacle for the patient -- for example, if you are in a rural community and the preferred pharmaceutical provider is not nearby -- you can discuss this with the claims adjuster or suggest that the patient contact an ombudsman to work out a solution.

Some doctors' offices dispense pharmaceuticals themselves. This dispensing is restricted by the WCA Rules. This section of the Rules is revised annually. As of 2008, a doctor's office may dispense no more than a 10-day supply of medication. See Rule 11.4.7.9.

To the pharmacist:

Payment for pharmaceuticals is governed by a formula in the medical rules. The pharmacist can find this information at Rule 11.4.7.9, Procedures for Establishing the Maximum Amount of Reimbursement Due, Section H. These rules are updated annually and available on the WCA web site.

You can check the web site for current updates or call the Medical Cost Containment bureau of the WCA.

Payments to hospitals and ambulatory surgical centers (§52-4-5-(G))

The workers' compensation law requires the WCA to apply a different method for determining the maximum payment to hospitals from that used for other health care providers.

See the subsection on hospitals and ambulatory surgical centers in Section 6 on Billing and Payment.

SECTION 5. Can this worker go back to work?

Can you approve sending this patient back to work?

- If not now, when?
- With what restrictions or limitations -- and are the restrictions or limitations temporary or permanent?

Your decision about whether to release your patient back to work is very important to your patient. The general rule of thumb is that your patient will be best off going back to work as soon as it is medically safe to do so. You are the judge of what is medically safe. This is due both to the psychological effects of going home versus going back to work and to the financial consequences of workers' compensation.

Psychological:

Workers who go back to work -- even those who say they don't like their jobs -- tend to be happier, have a better attitude toward their injury and get better faster than those who stay home.

Financial:

A worker is entitled to *temporary total disability benefits* (TTD) if, due to the work-related injury, he is unable to perform his pre-injury job (§52-1-25.1(A)).

A worker who loses seven or fewer days of work, though entitled to medical benefits, will not be entitled to indemnity benefits.

A worker who loses more than seven days of work becomes entitled to TTD benefits. These benefits are generally less than the worker would make by going back to work. The benefit structure is designed intentionally to give workers an incentive to get back to work.

Immediate return to work

Can the patient go back to work right away, perhaps with restrictions? Some possibilities:

- You might be asked for documentation in writing. This could be as simple as a note, or something more detailed such as a Return to Work form. Sample forms are in the Appendices. These forms are NOT required by law or rule. You are free to design your own form. Some payers have their own forms and ask you to use them.
- You may converse with the employer or claims representative about this subject, unless the patient or his lawyer objects. It's best to discuss this with the patient in advance of any such conversation and to document the patient's permission with a written, signed release. Keep your patient informed about these conversations. If the patient has an attorney, keep the attorney informed also. If any conversation with the employer or claims representative seems to be coercive or to interfere with medical treatment, you may end the conversation immediately and document what happened.
- If the patient cannot go back to regular full duty right away, other jobs might be available at his workplace. You may converse with the employer about alternative work options so

you can evaluate them and see if they are medically acceptable. Follow the guidelines in the paragraph above and in the Policy Directive in Appendix 8.

Your role is to establish the medical restrictions so that the employer can determine whether there is a job that the patient can do within those restrictions.

A patient who returns to work at a reduced wage before reaching medical stability will be entitled to *temporary partial disability benefits* (§52-1-25.1(C)), a portion of the difference between the pre-injury and post-injury wages. The patient will be better off financially by going back to work at a reduced wage than by relying on workers' compensation benefits.

Helping to find alternatives

If the patient will not be able to go back to his former employment, you can help him by advising him as early as possible to start making other plans. The injured worker might benefit greatly from using the recovery period to plan for a new type of work and perhaps use the time to take classes for new skills.

New Mexico workers' compensation does not require employers to provide vocational rehabilitation benefits. However, you are free to recommend some form of assistance if it has the potential to speed the completion of the claim. The New Mexico Division of Vocational Rehabilitation provides some vocational rehabilitation services free of charge.

Financial assistance for education may be available to injured workers who apply at their local community college or through other avenues. You can be helpful by encouraging your patient to check out the possibilities. The patient can call a WCA ombudsman for a list of valuable resources.

Documenting Return to Work

When your patient is ready to go back to work, provide clear written instructions about the patient's restrictions or limitations, if any, so that they are clear both to your patient and to the employer. You may refer to the sample Return to Work forms provided in Appendix 6. These forms are provided for your convenience as a suggestion. You are free to adapt or modify them.

The injured worker is required to provide information to the employer on her status regarding return to work (NMAC 11.4.3.12(A)) and, when released for work by the doctor, to provide written documentation on the work release, including any restrictions.

Rights of your patient regarding employment and rehire

If your patient was terminated by the employer, you could suggest that the patient call an ombudsman for information about his rights.

If your patient was terminated but is now ready to go back to work and could work for the same employer, you might suggest that the patient apply there. Under the law, the employer does not have to create a job for him. But the employer does have to give this worker preferential consideration for any job available that pays the same as or less than his old job and that he is

qualified and physically able to do safely (§52-1-50.1). An ombudsman at the WCA can give the patient more information.

Communicating with the employer

If the patient willingly gives you permission, you can converse with the employer or insurer. It is recommended that you obtain permission in writing through a release form that sets out the topics the patient has consented are open to discussion. (The patient is required by law to sign only the WCA release form, which is limited to written medical reports.)

If the patient is represented by a lawyer, make sure the lawyer is kept informed.

Maximum medical improvement -- what it is, and what it means for the patient (§52-1-24.1)

Maximum Medical Improvement or MMI is a medical determination that has critical legal consequences for your patient's workers' compensation case.

MMI is defined in the law as "the date after which further recovery from or lasting improvement to an injury can no longer be reasonably anticipated based upon reasonable medical probability as determined by a health care provider." It is the time when the patient is fully recovered, or, as sometimes described, "as good as he is going to get." It's the job of the authorized treating provider to decide when MMI occurs.

An injured worker temporarily unable to return to work receives *temporary total disability benefits* (TTD). At MMI, these benefits stop. This is the point at which most injured workers should be ready to go back to work. If the worker has a permanent physical impairment from this injury (explained in the next section), he will be entitled to a different type of benefit. The most common types of post-MMI benefits are *permanent partial disability benefits* (PPD) or *scheduled injury* benefits. These benefits are usually much less money than TTD. In most cases PPD will not be enough for the injured worker to live on.

Unfortunately, many injured workers are not prepared for the reality of PPD. You can help by informing your patient of this reality -- well in advance, so that it is not a surprise when it happens. One simple way to do this is to encourage the patient to obtain copies of WCA publications.

You can also help by notifying the claims representative promptly when your patient reaches MMI. If you notify the claims representative late, it is possible that an overpayment of indemnity benefits will have been made, and your patient might owe money back to the insurer.

You may be contacted by the claims representative and asked to predict when MMI will occur. You are free to give estimates, but you are not required to set a date for MMI in advance or to be bound by an estimated date if you have offered one.

It is rare but possible for MMI to occur more than once. For example, the patient may reach MMI and then suffer an unexpected setback at a later time, leading to another period of temporary disability.

Calculating impairment ratings

An impairment rating is a measure of the permanent damage to the worker's body. The current edition of the *American Medical Association Guides to the Evaluation of Permanent Physical Impairment* is recognized in New Mexico law as the official guide to calculating this rating (§52-1-24).

The impairment rating will be used to determine your patient's PPD benefits. By law, only an MD, DO or DC can perform an impairment rating (§52-1-24.1 and §52.4.1).

You may decide whether you feel qualified to calculate your patient's impairment rating or whether to refer to a specialist. The Rules of the WCA state that the process of assessing the impairment rating must be pre-approved for payment by the payer (NMAC 11.4.7.9.B(4)). Get approval in advance from the insurer or self-insurance program, to be sure you will be paid for your services.

With regard to the following section, you are responsible only for determining the patient's impairment. Information about your patient's benefits is provided as a matter of interest, but you are not responsible for it.

Two ways to figure impairment: scheduled injury or whole body

For purposes of long-term disability benefits, the New Mexico workers' compensation law divides all injuries into two major types: scheduled injuries and whole body injuries. This division is in the workers' compensation law, not the *AMA Guides*.

Scheduled injury (§52-1-43):

A *scheduled injury* is an injury limited to a specific body part, usually part of a limb. The scheduled injuries are listed in a "schedule" in the law, which specifies the number of weeks of benefits to be paid for that particular body part -- ranging from seven weeks for the smallest section of the fourth finger to potentially 200 weeks for a whole leg or the "dextrous" arm.

A worker with a scheduled injury receives TTD as for other injuries until he reaches MMI. After that, the worker may be entitled to benefits for the period specified in the schedule, based on a standard known as "loss of use," which is different from an impairment rating. The schedule is in Appendix 2.

Whole body injuries (§52-1-42):

A *whole body injury* is any injury that affects the body as a whole, or, as the statute says, any injury that is not specifically provided for in the schedule. Whole body injuries are usually to the head, neck, shoulder, back, hip or multiple body parts.

Most injuries fall clearly into the category of whole body or scheduled injuries, but there are circumstances in which the subject can be argued, and you might be asked for an evaluation or

opinion. For example, an injury to the arm that affects the shoulder, where the effect may or may not extend to the functioning of the upper torso, could be argued in a litigated case.

There are two variations on whole-body benefits, depending on whether the worker has returned to work at or above his pre-injury wage: impairment only or impairment with “modifiers.” **These variations are explained in the next section as a matter of general interest. You are not responsible for calculating the injured worker’s benefits.**

Whole body -- impairment only (§52-1-26(D))

The worker’s weekly TTD benefit is multiplied by the impairment rating (which is expressed as a percentage). If, after MMI, the worker is back to work earning at least the pre-injury wage, the worker is entitled to receive permanent partial disability benefits, at the compensation rate multiplied by the impairment rating. For example, a worker whose TTD benefit was \$300 a week and whose impairment rating was 10 percent would receive \$30 a week.

Whole body -- impairment with modifiers (§52-1-26(C) and §52-1-26.1 through §52-1-26.4)

If at the time of MMI the worker cannot medically return to work, or is earning a lower wage, or has not been offered a job he can perform, the worker is entitled to receive additional money in benefits. This additional amount is based on a formula containing “points” for the worker's age, education, and reduction in physical capacity -- all factors likely to affect the worker's future ability to earn a living. These factors are called “modifiers.”

The formula is not presented in this book because you are not responsible for it. Put simply: an older worker receives more points than a younger worker. A worker with less education receives more points than a worker with more education. These factors are based on the general assumption that an older worker, or one with less education, is at a disadvantage in future earning potential.

If the total PPD rating (including the impairment rating and formula points) is less than 80%, the duration for any whole-body PPD injury is 500 weeks of benefits including TTD and PPD. If the PPD rating is 80 percent or more, benefits are paid for 700 weeks (§52-1-42.A(1) and (2)).

Physical capacity modification (§52-1-26.4)

The physical capacity modification is the one factor in the PPD formula that requires a decision from a health care provider. The doctor must evaluate the worker’s current physical capacity and decide whether it is heavy, medium, light or sedentary, according to the definitions below.

If necessary, this may be determined through a *functional capacity evaluation* performed by a physical or occupational therapist on referral from the treating physician. The medical opinion must be the physician’s.

The physical capacity descriptions given below are taken directly from the statute:

- **"Heavy"** means the ability to lift over 50 pounds occasionally or up to 50 pounds frequently;
- **"Medium"** means the ability to lift up to 50 pounds occasionally or up to 25 pounds frequently;
- **"Light"** means the ability to lift up to 20 pounds occasionally or up to 10 pounds frequently. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm or leg controls or both; and
- **"Sedentary"** means the ability to lift up to 10 pounds occasionally or up to 5 pounds frequently. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

The worker's current rating will be compared to the physical capacity necessary to perform the worker's pre-injury job to determine points in the formula. **You do not have to be concerned with the points, just the current capacity rating after MMI.**

Permanent total disability (§52-1-25)

A worker who qualifies for *permanent total disability* benefits (PTD) is entitled to weekly benefit payments for life.

To be eligible for permanent total disability benefits, the worker must have suffered either:

- the permanent and total loss or loss of use of both hands or both arms or both feet or both legs or both eyes or any two of the listed body parts, or;
- a severe disabling brain injury resulting from a single traumatic work-related accident, leaving a 30 percent impairment (based on the brain injury alone) as defined by the current *AMA Guides*.

A worker with permanent total disability qualifies for property tax relief on New Mexico real property. Please refer your patient to Booklet B2 or a WCA ombudsman.

Treatment, referrals and pre-approvals

The workers' compensation law (§52-1-49) requires the employer to provide the worker with timely, reasonable and necessary health care services from a health care provider, to continue as long as treatment is necessary.

"Reasonable and necessary" is the key phrase. You don't have unrestricted freedom to provide every possible treatment modality and expect the insurer or self-insurance program to pay for it. Neither are you limited to the least expensive option.

Workers' compensation claims adjusters generally want their claimants to get well as quickly as possible. The cost of the claim includes not only your bills but also the indemnity payments to the patient. If the patient becomes dissatisfied and hires an attorney, the costs are likely to be higher.

Many insurers agree that it's cost-effective to support a rapid recovery, enabling the worker to reach MMI and return to work. Some insurers encourage the use of medical resources in the early weeks following an injury, believing this can speed healing and return to work, and ultimately will cost less.

What you should do

You are the recognized expert in your patient's needs for treatment, diagnostic procedures, referrals, etc. Your medical opinion counts a great deal.

For most types of treatment, diagnostic procedures, etc., the law does not require you to get pre-approval. (Exceptions include anything covered under the WCA utilization review program and certain procedures and examinations specified in the Rules of the WCA, NMAC 11.4.7.9.B). However, asking for pre-approval is common practice.

Pre-approval by the WCA

The WCA is required by law to implement both a utilization review and a case management program. This will require certain pre-approvals. The program may change from time to time. See Section 7, "Utilization Review and Case Management," for more information. You may want to contact the Medical Cost Containment bureau of the WCA occasionally to ask about any changes in the utilization review and case management programs.

Use of release forms

The WCA has a release form that permits the release of medical records. The patient is required to sign this release as a condition of receiving workers' compensation benefits, under the Rules of the WCA. Copies of the release form in English and Spanish are in Appendix 4 and 5.

Workers' compensation is specifically exempt from HIPAA under the federal HIPAA law; however, to ensure that you are confident about HIPAA compliance, the WCA form for release of medical records is HIPAA compliant.

The patient is not required to sign any other release but may do so voluntarily. If the patient signs any other release as a result of being coerced or misinformed, that could be an unfair claims practice under the workers' compensation law.

- Written communication is permissible. Certain types of documents are specifically permitted to be shared. Those documents are listed in Paragraph 3 of the WCA Approved Release Form and include:

medical reports; clinical notes; nurses' notes; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; hospital bills; bills for services the HCP has rendered; payments received; and any other relevant and material information in the HCP's possession; if applicable, any hospital operational logs, emergency logs, tissues committee reports, psychiatric reports and records, physical therapy records, and all outpatient records; and the Form Letter to HCP as approved by the Workers' Compensation Administration.

- If the patient objects to informal conversations between you and the employer or insurer, or if the patient is represented by a lawyer, then, before any telephone call or in-person conference between you and the employer or insurer, the patient or the patient's attorney should be given the opportunity to be present. If the patient waives this right, you can go ahead and have the conversation without them. If not, the contact should not be made.

The claims representative may contact you from time to time for a progress report, including such matters as your estimate of when the patient will reach maximum medical improvement and when the patient might be able to return to work. One simple way to answer these concerns is to use the Form Letter to Health Care Providers (see copy in Appendix 3) and provide the information in writing. You may bill for this service. As of publication date, the maximum charge for filling out this report is \$45; this is subject to change through the Rules.

Your patient has a right to copies of medical reports, if he requests them.

SECTION 6. Billing and payment

Rules governing billing and payment

This section provides general guidelines on billing and payment under the New Mexico workers' compensation system, including what to do about documentation demands, billing disputes, and delay in payment of your bills. It attempts to answer questions commonly asked by doctors and their administrative staffs.

This section is an overview based on the Rules of the Workers' Compensation Administration, primarily Part 7, titled *Compilation of Medical Rules and Fee Schedule*. The rules are detailed with respect to specific medical procedures and situations. It is recommended that you obtain a copy of the rules and review them. They are available from any office of the WCA or downloadable from the WCA web site at www.workerscomp.state.nm.us.

Hospitals and ambulatory surgical centers are governed by a different set of rules from all other health care providers. Please see the end of this chapter.

Information needed with your bill (WCA Rules, NMAC 11.4.7.10)

It is recommended that you read and follow the billing guidelines in the Rules of the WCA. Here are a few basic items for you to be aware of.

- You must use standard CMS forms.
- The bill must have "WORKERS' COMPENSATION" or "WORK COMP" clearly printed or stamped at the top.
- The Rules require outpatient services to be billed within 30 days of the service (NMAC 11.4.7.10(A)6). For other services, see the Rules for deadlines.
- You must provide CPT codes and descriptors.
- Along with the bill, you must provide medical records (office notes) substantiating the services you have provided (NMAC 11.4.7.10(D)). The notes must be legible. You may not charge for the initial copy of medical records.
- If you are asked for any special reports in addition to medical notes, or for additional copies of medical records, you can bill for this additional service, under the Rules.

Medical notes are important to the payment of your bill. The adjuster has a responsibility to review medical services, to be sure they are reasonable and necessary.

Consider organizing your files so that it will be easy and efficient for you to include medical notes with your bill.

Documenting causation

It may be advisable in your initial bill to include a simple statement of your medical opinion as to whether the patient's condition was caused by a work-related accident, to a reasonable medical probability. That information could speed the processing and payment of your bill.

How much will I be paid for my services (§52-4-5)?

The workers' compensation law regulates the amount of payment that providers may receive for their service.

The WCA issues a medical fee schedule, currently called the Physicians' Fee Schedule or PFS. You may bill according to your usual and customary fees, but the payer is required by law to pay no more than the amount on the PFS. If the PFS for a particular item is lower than your fee, the payer should pay only the PFS amount.

The title of the schedule was changed to PFS at the end of 2007. Previously the schedule was titled the Schedule of Maximum Allowable Payments or MAP.

Usually the schedule is updated once a year. The law requires the WCA to adjust the schedule on the basis of current rates for providers, using a variety of billed charges sources.

For treatments or procedures not listed on the schedule, a "by report" option is available. Contact the Medical Cost Containment Bureau of the WCA for more information.

The WCA also regulates payments for non-medical services, such as providing copies of documents, testifying in legal cases, etc.

Copies of the PFS

For copyright reasons, the PFS is available online only in a limited format, which lists codes and prices but no descriptors.

You can download a copy from the WCA web site at www.workerscomp.state.nm.us. You must register for the download and agree to copyright restrictions based on the WCA's agreement with the American Medical Association.

The printed version is available free of charge from the WCA. You can pick up copies in person at any office of the WCA.

To obtain printed copies by mail, you will be asked to provide a self-addressed stamped envelope with correct postage. Call the WCA reception office for the current correct postage. Please see the instructions in Section 1 under, "To obtain copies of the WCA Rules and Medical Fee Schedule."

Older editions of the medical fee schedule are titled the Schedule of Maximum Allowable Payments, or MAP, and are available only in print. Call any office of the WCA for assistance.

The WCA Rules associated with the fee schedule are available online. The title is Rules Governing Payments for Health Care Services, Part 7 of the WCA Rules. Go to the WCA web site at www.workerscomp.state.nm.us. Click through Legal to Rules and download Part 7.

Services not covered by the PFS (NMAC 11.4.7.9(F)10)

Some services are not listed in the PFS. These services are payable on a “by report” or “BR” basis. The fee should be negotiated between the payer and provider before the service is performed.

Gross receipts tax (NMAC 11.4.7.7.BB)

You may add gross receipts tax to your bill. New Mexico gross receipts tax is paid in addition to the net amount payable according to the PFS. Your gross receipts tax requirements may be affected by recent changes in New Mexico tax law.

Missed appointments (NMAC 11.4.7.9.G(17 and 18))

You are permitted to charge for a failed initial appointment but not for established patients. See Rule 11.4.7.9.G(17 and 18) for the special CPT code. A patient who repeatedly misses appointments may jeopardize his claim.

Balance billing

If you have a dispute over the amount of a bill or the timeliness of payment, that is between you and the payer, not the injured worker. You may not bill the worker for any payments for a workers' compensation covered injury or condition, nor balance-bill for the portion not paid by the responsible payer.

If it is determined that this patient's condition is not covered by workers' compensation, the patient becomes responsible for the bill, and you may bill the patient or other insurance.

Treatment other than the work-related injury or condition

The workers' compensation insurer or self-insurance program is required to pay only for treatment for the work-related injury or condition.

If you are treating your patient for any other health problem, do not bill the workers' compensation payer for that treatment.

What about contracts that require us to accept a lower payment?

An insurer or self-insurance program may offer you a contract and ask you to accept lower payments based on the insurer's own fee schedule. If you do, you might become a preferred provider and receive referrals from that insurer or self-insurance program.

You do not have to sign any such contracts. If you do not have a contract, you are not required to accept the lower payment. If the payer is delaying payment, requiring unreasonable documentation, or insisting on paying less than the PFS, that payer might be in violation of law.

You can report your problem to the Medical Cost Containment bureau of the WCA and seek an informal resolution of the issue. See "Billing and Payment Disputes."

Billing and payment disputes (NMAC 11.4.7.13)

The WCA has procedures to help you resolve billing and payment disputes.

You can follow these procedures to communicate with the payer. If you resolve the issue privately, the WCA does not have to be directly involved. In cases where you cannot reach agreement, the WCA can assist. Contact the Medical Cost Containment Bureau.

You should receive your payment -- or an explanation of the denial of payment -- within 30 days of the day you sent the bill. If you don't receive any communication, you can start the dispute resolution process by using the Demand for Notice of Contested Billing form (see Appendix 7). However, you might need proof that your bill was received. You might have to send a second bill, using Certified Mail with return receipt requested.

If you experience payment delay problems with a particular payer, you could make a habit of following up your bills with a phone call to be sure the payer received the bill.

If you need to go further than these simple steps, refer to the Rules (NMAC 11.4.7.13) for billing and payment disputes. The rules provide the detailed steps to be followed.

Administrative penalties against uncooperative payers

A payer who consistently delays payment or pays incorrect amounts may be violating the "unfair claims practices" requirements of the workers' compensation law and could be subject to penalties. You can report such a payer to the WCA Enforcement bureau.

Hospitals and ambulatory surgical centers (§52-4-5(G))

The law requires the use of a "ratio" method for hospitals. Each hospital has been assigned a ratio based on information submitted by the hospital to the WCA. That ratio sets the percentage of the hospital's billed charges that are to be paid. However, payments for some kinds of services are to be done under the Physicians' Fee Schedule.

The rules governing payments to hospitals and ambulatory surgical centers have been updated each year in recent years and will continue to receive annual updates due to changing practices in the industry. In general, each year's rule is in effect for a full year and expires at the end of the calendar year (Rules of the WCA, 11.4.7.9 (F)). The rule can be downloaded from the WCA web site at www.workerscomp.state.nm.us.

Information is available from the Medical Cost Containment Bureau of the WCA.

SECTION 7. Utilization Review and Case Management

Utilization review (§52-4-2)

The New Mexico workers' compensation law requires the Workers' Compensation Administration to maintain a utilization review program as a cost containment measure.

This program has changed from time to time and is subject to change through the WCA rules revision process. As of this publication date, the program is a **mandatory pre-authorization of all in-patient hospital admissions**. If hospitalization is required, someone must contact the Medical Cost Containment bureau and notify the staff of the number of days of hospitalization required. Check with your claims representative for current utilization review requirements and to determine who will obtain the pre-authorization.

Case management (§52-4-3)

Case management is sometimes used for patients with serious injuries that may be considered catastrophic or have a high potential for becoming chronic. A case manager, usually a nurse, may provide a valuable service in coordinating care, ensuring that the patient keeps appointments and identifying opportunities for the patient to return to work.

A case manager can be assigned to a patient by one of two sources: the payer or the WCA.

WCA- assigned case manager:

The law requires the WCA to implement a case management program. This program has changed from time to time and is subject to change through the WCA rules revision process.

As of this publication date, the WCA program involves the assignment of a case manager to a patient upon request of any party, subject to the discretion of the Director. The case managers work on contract to the WCA. A WCA assigned case manager may report to the WCA but not to the payer. You are required to cooperate with a WCA assigned case manager with respect to all reasonable requests for information necessary for any provision of service (NMAC 11.4.7.14.A.1).

If you think a patient may benefit from case management services, you may call the WCA to request them. Contact the Medical Cost Containment bureau.

Payer-assigned case manager:

The payer may choose to assign a case manager. You are not required to violate the patient's privacy by providing more information to a case manager than you are otherwise required to provide to the payer.

As noted in the section on Billing and Payment, you are required to provide one copy of medical records to the payer free, but you may charge for additional copies. If a case manager asks you for copies of medical records you have already sent to the payer, you may charge for them. A case manager normally should be expected to obtain copies from the adjuster, and generally should stay in coordination with the adjuster.

SECTION 8. Your role in disputes between the worker and the employer/insurer

How disputes are handled in New Mexico workers' compensation

Disputes between injured workers and their employers/insurers are handled through the administrative law court of the Workers' Compensation Administration. Disputes are usually started with a complaint filed by the worker, but in some cases the complaint may be filed by the employer or insurer.

The dispute resolution process is designed by law to minimize costs wherever possible, as long as that is consistent with the rights of the parties. If the dispute can be resolved simply, your formal testimony might not be necessary. Mandatory mediation is the first step in attempting to resolve the dispute.

Form Letter to Health Care Providers (form attached to NMAC 11.4.4.14)

The Form Letter to Health Care Providers is a questionnaire that you will be asked to fill out. This questionnaire asks you for the essential information necessary for the dispute.

A copy of the form, effective as of the date of this publication, is in Appendix 3. You can download the current form from the WCA web site.

This form is very important to your patient's case. When you are asked to complete the form, please do so promptly. Mail a copy of the completed form to your patient and another to the Workers' Compensation Administration, to the attention of the Court Clerk.

The maximum allowable payment you may receive for this service is currently \$45. This is subject to change in the Rules of the WCA (NMAC 11.4.7.9.B (11) and 11.4.7.15, Non-Clinical Services).

Who can testify

Under the workers' compensation law, only certain health care providers are permitted to give medical testimony about the worker's condition:

- providers who are or have been the authorized treating provider in this case;
- providers who have treated this worker on referral from either the current or former authorized treating provider in this case;
- providers who have performed independent medical examinations of this worker in this case.

Depositions

If there is a dispute between the worker and employer/insurer, you could be asked to testify. Medical testimony is usually taken in depositions rather than in court. (NMAC 11.4.4.12(G))

The hourly fee for depositions, plus payment for travel and other incidentals, is governed by the Rules (11.4.7.15, Non-Clinical Services). Under the current rule (effective as of this publication date), time spent preparing for deposition is not billable. Please check the Rules for all current details on what is covered and what is not.

Independent Medical Examinations

Independent Medical Examinations or IMEs can be conducted at any time to resolve any disputed issue that requires an expert medical opinion. The IME will be paid for by the insurer or self-insurance program.

The IME can be ordered at the request of either the worker or the employer / insurer. If those parties agree on the selection of a doctor to perform the examination, the selection does not require any formal court action.

A workers' compensation judge may select the IME provider on the request of either party.

The Rules of the WCA state that the IME must be pre-approved by the payer (11.4.7.9.G(3)a) or by court order. Get the approval in advance to be sure you will be paid for your service.

The IME Provider List (§52-1-51(B))

Are you interested in performing independent medical examinations?

Any qualified health care provider with a relevant specialty can perform an IME if selected by agreement of the two parties. To perform an IME by the appointment of a workers' compensation judge, the doctor must have previously qualified by being listed on the WCA's IME Provider List.

Under the workers' compensation law, a workers' compensation judge normally may select an IME provider only from a list of providers approved by the IME Provider Selection Committee. An exception is made if the IME requires a specialty and there is no provider from that specialty on the list.

The IME Provider Selection Committee is made up of three representatives from business and three from labor. These members are appointed by the Advisory Council on Workers' Compensation and Occupational Disease Disablement, which is appointed by the Governor.

The IME Provider Selection Committee has simplified the application process to encourage providers to apply for the list; however, the committee is free to change its selection process and criteria from time to time. If you are interested in being a listed IME provider, contact the Medical Cost Containment Bureau of the WCA for the current application procedure.

Glossary of Terms

Adjuster

A person who "adjusts" claims while working for an insurance company, a self-insurance program, or a third party administrator. An adjuster makes decisions about benefit payments and authorizes writing the checks. He/she is one type of claims representative.

AMA Guides

American Medical Association Guides to the Evaluation of Permanent Physical Impairment; a book published by the American Medical Association, describing how to rate the impairments of injured workers. The current *AMA Guides* is the official standard for rating workers' compensation injuries in New Mexico.

"At-injury" employer

The employer for which the patient was working when injured. Workers' compensation law gives the worker certain rights with respect to this employer, including rights for preferential consideration in rehiring.

Benefit

Any payment to an injured worker or in behalf of an injured or deceased worker for compensation, medical treatment, legal expenses, funeral or travel costs resulting from a work-related injury, illness or death.

Case management

Coordination of medical and related activities for a patient by a specialist, usually a nurse. By law, the Workers' Compensation Administration administers a case management program, which may change from time to time. Case management services provided by the insurer or self-insurance program are neither required nor prohibited by law.

Claims Representative

A person from an insurance company, self-insurance program, or third party administrator who works on the worker's claim. This person is the worker's contact person for matters concerning the worker's claim, benefits, payments and other matters.

Complaint

A legal document filed in a workers' compensation dispute; it is a special type of lawsuit handled through the Workers' Compensation Administration.

Disability rating

A percentage value for an injured worker that includes the impairment rating and, if appropriate, factors for age, education, training, and the change in the worker's physical ability. A disability rating is used to determine PPD benefits for an injured worker who cannot return to work.

Employer's First Report of Injury (E-1)

The form that an insurer or self-insurance program is required to file with the WCA to provide a record of a worker's compensation claim. Most E-1 forms are filed electronically without use of paper. The employer or insurer is required to provide the worker with a copy of the E-1.

Functional capacity evaluation

An assessment of the injured worker's ability to lift weight and perform other work functions, done by a physical or occupational therapist through physical testing.

Health Care Provider (HCP)

A person or organization that provides health care services. By law, the health care provider may be in any one of these professions: medical doctors, optometrists, chiropractors, dentists, podiatrists, osteopathic physicians, physician assistants, certified nurse practitioners, physical therapists, occupational therapists, acupuncture practitioners, psychologists and certified nurse-midwives.

Impairment

Injury-caused mental or bodily damage that is expected to be permanent.

Impairment rating

A percentage number used to "rate" the permanent impairment of an injured worker. An impairment rating can only be given by the treating health care provider or an independent medical examiner and must be based on the current *AMA Guides*.

Indemnity Payment

A payment to the injured or ill worker or dependents to compensate for wage loss, functional impairment, or death.

Independent Medical Examination (IME)

An examination of the injured worker, conducted by a health care provider who has not treated this worker, to resolve any disputed issue that requires an expert medical opinion. If the examiner is selected by agreement of the parties, the examiner may be any health care provider of the relevant specialty. If the parties cannot agree and the examiner is selected by a workers' compensation judge, the examiner must be selected from a list.

Loss of Use

A term associated with scheduled injuries (§52-1-43). Loss of use does not require impairment under the *AMA Guides*. It considers impairment, medical restrictions, patient symptoms and changes in behavior that are the result of a work accident and injury. There is no specific method in the law for determination of loss of use. It is often expressed as a percentage of a particular body part.

Lump Sum Payment

A single workers' compensation indemnity payment in place of future installment payments.

MAP

See "Schedule of Maximum Allowable Payments"

Maximum Medical Improvement (MMI)

The date after which further recovery from or lasting improvement to an injury can no longer be reasonably anticipated as a result of further medical treatment, based upon reasonable medical probability as determined by a health care provider.

Medical benefits

Payment by the insurer to a health care provider for an injured worker's medical care

Mediation

An informal meeting involving both sides of a workers' compensation dispute with a WCA mediator to try to resolve the dispute.

Mental impairment

A mental condition that was the result of the accident or injury.

Mileage Rate

An amount of money paid for every mile approved for travel to get to medical treatment that is required by the worker's compensation claim; paid only if the patient has to travel 15 or more miles each way.

Modified work

A job that has been changed to allow a worker with physical limitations to do it.

Notice of Accident Form

A two-part carbonless form that each employer is required by law to post on or near the Workers' Compensation poster at the workplace, to allow employees to report accidents in writing.

Occupational Disease

A disease that is caused or partly caused by the specific job a worker does.

Ombudsman

An employee of the Workers' Compensation Administration who provides neutral information and assistance on request to any party in a workers' compensation claim. The ombudsmen may be contacted by telephone or in person at all WCA offices.

Permanent partial disability (PPD)

A category of indemnity benefit, payable when a worker has a permanent physical impairment after reaching maximum medical improvement. The amount of benefits is determined by the worker's physical impairment, as rated by the AMA Guides, and, if the worker is unable to return to work, by a formula based on the worker's age, education and residual physical capacity.

Permanent total disability (PTD)

A category of indemnity benefit, payable when a worker has been left with the permanent and total loss or loss of use of both hands or both arms or both feet or both legs or both eyes or any two of them, or a disabling brain injury.

Physical capacity (PC)

A rating of an injured worker's ability to perform physical tasks compared to the physical tasks the worker usually performed in his work before any injury, based on statutory standards of "heavy," "medium," "light" and "sedentary." Also called "**residual physical capacity**."

Physicians' Fee Schedule (PFS)

A list of procedure codes and the maximum payment permitted for each code when billed for a New Mexico workers' compensation claim. PFS became the title of the fee schedule as of 2008 (taking effect on December 31, 2007).

Schedule of Maximum Allowable Payments (MAP)

A list of procedure codes and the maximum payment permitted for each code when billed for a New Mexico workers' compensation claim. MAP was the title of the fee schedule produced by the Workers' Compensation Administration through 2007. The fee schedule has been renamed Physicians' Fee Schedule or PFS.

Self-insured

An employer that provides workers' compensation coverage for its employees through its own financial resources rather than an insurance policy. Self-insured employers must be approved and are audited by the WCA. They are required to meet a high standard of financial solvency.

Self-insured group

An organization composed of employers engaged in the same or similar types of business, that have joined together for the purpose of providing workers' compensation coverage for their employees. Self-insured groups must be approved and are audited by the WCA. They are required to meet a high standard of financial solvency.

Self-insured pool

A group of local government agencies that have joined together for the purpose of providing workers' compensation coverage for their employees. Self-insured pools are audited by the WCA.

Temporary partial disability

Indemnity payments made to a worker who continues working following the injury, but suffers a temporary reduction in wages. The benefit payments make up part of the difference between the old and new wages.

Temporary total disability

Indemnity payments made to the worker based on the inability of the worker, by reason of accidental injury arising out of and in the course of his employment, to perform his duties, up to the date of maximum medical improvement.

Third party administrator (TPA)

A representative hired by an insurance company or self-insurance program to handle workers' compensation claims.

Uninsured Employer Fund (UEF)

A program administered by the WCA to provide coverage for injured workers whose employers were illegally uninsured. Claims paid by the UEF are handled by a third party administrator. The WCA seeks to recover the cost of the claim and substantial penalties from the uninsured employer.

Utilization Review

Review of selected health care services. By law, the Workers' Compensation Administration administers a utilization review program, which may change from time to time. Utilization review by the insurer or self-insurance program is neither required nor prohibited by law.

Workers' Compensation Administration (WCA)

The New Mexico state agency that regulates workers' compensation and provides the administrative law court for resolution of disputes.

APPENDIX 1: Bureaus and functions of the WCA of interest to health care providers

Reach all bureaus by telephone at the numbers listed at the end of this book. This summary describes only the functions of interest to health care providers.

Advisory bodies

Advisory Council on Workers' Compensation and Occupational Disease Disablement:

This is a volunteer Council appointed by the Governor, composed of three representatives from business and three from labor. The Council serves in an advisory capacity to the Governor and Legislature and can originate legislative recommendations. Anyone can contact the Council to bring issues to the Council's attention. Staff support for the Council is coordinated by the Director of the Workers' Compensation Administration.

IME Provider Selection Committee:

This volunteer committee consists of six members appointed by the Advisory Council on Workers' Compensation and Occupational Disease Disablement. The committee usually meets about twice a year. It approves a list of providers who may be appointed by a judge to perform an independent medical examination. Administrative support for this committee is done by the Medical Cost Containment Bureau.

WCA bureaus

Medical cost containment:

This bureau administers the medical fee schedule, the hospital fee program and the utilization review and case management programs. Assists parties with billing and payment issues.

Economic research:

This bureau gathers and analyzes statistical information, producing the annual updates to the medical fee schedule and analyzing the effects of changes. The bureau receives reports of injuries and costs filed by insurer or self-insurance programs. It produces the WCA Annual Report and special studies. (The complete WCA Annual Report is available online as well as in print.)

General Counsel:

This office is responsible for drafting rules revisions and receiving and responding to public comment on rules.

Ombudsmen:

These staff members are available by telephone and in person at all offices of the WCA. They are specialists in workers' compensation claims, can answer questions from any party and can help to prevent or resolve some disputes informally. There are Spanish-speaking ombudsmen on staff.

Field offices:

The WCA state headquarters are located in Albuquerque. Field offices are in Santa Fe, Las Vegas, Las Cruces, Farmington, Lovington and Roswell. Contact your nearest field office for publications, ombudsman services, safety consultation services and more information.

Dispute Resolution and Court Clerk:

Workers' compensation mediators and judges, as well as support staff, are in the Dispute Resolution bureau. It is usually not permissible to contact a mediator or judge privately if you are a witness in a dispute; for administrative matters such as hearing schedules, you may contact the Dispute Resolution support staff or the Court Clerk's office.

APPENDIX 2: The Schedule of Injuries to Specific Body Members (§52-1-43)

Injury	Compensation Benefits Number of Weeks
(1) one arm at or near shoulder, dextrous member	200 weeks
(2) one arm at elbow, dextrous member	160 weeks
(3) one arm between wrist at elbow, dextrous member	150 weeks
(4) one arm at or near shoulder, nondextrous member	175 weeks
(5) one arm at elbow, nondextrous member	155 weeks
(6) one arm between wrist and elbow, nondextrous member	140 weeks
(7) one hand, dextrous member	125 weeks
(8) one hand, nondextrous member	110 weeks
(9) one thumb and the metacarpal bone thereof	55 weeks
(10) one thumb at the proximal joint	34 weeks
(11) one thumb at the second distal joint	22 weeks
(12) one first finger and the metacarpal bone thereof ..	28 weeks
(13) one first finger at the proximal joint	22 weeks
(14) one first finger at the second joint	17 weeks
(15) one first finger at the distal joint	12 weeks
(16) one second finger and the metacarpal bone thereof .	22 weeks
(17) one second finger at the proximal joint	17 weeks
(18) one second finger at the second joint	12 weeks
(19) one second finger at the distal joint	10 weeks
(20) one third finger and the metacarpal bone thereof ..	17 weeks
(21) one third finger at the proximal joint	12 weeks
(22) one third finger at the second joint	10 weeks
(23) one third finger at the distal joint	10 weeks
(24) one fourth finger and the metacarpal bone thereof .	14 weeks
(25) one fourth finger at the proximal joint	14 weeks
(26) one fourth finger at the second joint	10 weeks
(27) one fourth finger at the distal joint	7 weeks
(28) loss of all fingers on one hand where thumb and palm remain	70 weeks
(29) one leg at or near hip joint, so as to preclude the use of an artificial limb	200 weeks
(30) one leg at or above the knee, where stump remains sufficient to permit the use of an artificial limb	150 weeks
(31) one leg between knee and ankle	130 weeks
(32) one foot at the ankle	115 weeks
(33) one great toe with the metatarsal bone thereof	35 weeks
(34) one great toe at the proximal joint	17 weeks
(35) one great toe at the second joint	12 weeks
(36) one toe other than the great toe with the metatarsal bone thereof	14 weeks
(37) one toe other than the great toe at the proximal joint	10 weeks
(38) one toe other than the great toe at second or distal joint	8 weeks
(39) loss of all toes on one foot at proximal joint	40 weeks
(40) eye by enucleation	130 weeks
(41) total blindness of one eye	120 weeks
(42) total deafness in one ear	40 weeks
(43) total deafness in both ears	150 weeks

APPENDIX 3: Form Letter to Health Care Providers

Amended form, October, 2007, based on rules of August 2005.

This form is mandated by the WCA Rules, 11.4.4.9 (R).

The form itself is part of Attachment A to Part 4 of the WCA Rules (Claims Resolution).

This form may be downloaded as a “pdf” or Word file from the WCA web site, www.workerscomp.state.nm.us.

The Word version allows you to fill out the form on your computer.

Look under “Forms.”

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION
FORM LETTER TO HEALTH CARE PROVIDER

Instruction to the person submitting this form to the health care provider:

Along with this form, you must provide a copy of the WCA- approved medical release form that has been signed by the Worker within the last 6 months.

TO: HEALTH CARE PROVIDER (name and address)

RE: Worker: _____ WCA No.: _____

Date of birth: _____ Social Security number: _____

Attached is a release of medical information by the Worker/Patient. The information requested in this letter is necessary to evaluate the Worker's legal claims. By promptly completing these forms, you speed the process of evaluation, including whether medical bills should be paid by the insurance carrier. Please answer all questions which you believe to be pertinent. Your answers must be based upon a reasonable medical probability.

1. Who referred Worker to you for treatment? _____

2. Date of Worker's most recent visit or treatment: _____

3. What is your diagnosis of the condition(s) for which you have treated the Worker?

4. In your opinion, are the conditions or complaints for which you have treated the Worker causally related to an on-the-job injury? Yes___ No___

Date of injury: _____

5. Is the Worker suffering from a disease that, in your opinion, is related to employment? Yes___ No___

Date of occurrence: _____

6. Indicate the period of time the Worker has been unable to work: _____
7. Is Worker able to return to work? Yes____ If yes, same job? _____ Different job? _____
 Any restrictions? _____
 No____ If no, when do you anticipate a return to work? _____
8. Has the Worker reached the date after which further recovery from, or lasting improvement to, an injury can no longer be reasonably anticipated (MMI)? Yes____ Date of MMI: _____
 No____ Anticipated date of MMI: _____
9. If the Worker has reached MMI, please indicate your opinion as to the percentage of the Worker's anatomical or functional abnormality existing after the date of MMI:
- a) Percentage of impairment, if any: _____
 - b) Whole body or body part: _____
 - c) Indicate which edition of AMA Guides used: _____
 - d) AMA page numbers _____
10. Has a Physical Capacities Assessment or Functional Capacity Evaluation been performed?
 Yes____ No____
 Was the evaluation performed by a licensed physical therapist or occupational therapist? Yes____ No____
11. Can the Worker:
- a) Lift over 50 pounds occasionally or up to 50 pounds frequently? Yes____ No____
 - b) Lift up to 50 pounds occasionally or up to 25 pounds frequently? Yes____ No____
 - c) Lift up to 20 pounds occasionally or up to ten pounds frequently, and either walk or stand to a significant degree, or sit most of the time with a degree of pushing and pulling arm or leg controls or both? Yes____ No____
 - d) Lift up to ten pounds occasionally or up to five pounds frequently, and occasionally walk or stand to carry out job duties? Yes ____ No____
- Comments: _____

12. Please describe any other restrictions on Worker's activities not covered above:

13. Other remarks: _____

14. Have you made any referrals to other health care providers, hospitals or institutions? Yes___ No___
If yes, provide the name: _____

15. Please attach a copy of any unpaid bills.
The maximum allowable fee you may charge for this form is \$45.00. The fee for copying of medical records and reports for the first ten (10) pages is \$10.00, and \$.20 cents for each additional page.
I hereby affirm that the foregoing responses or opinions are true and correct to a reasonable medical probability.

Date: _____

Signature of Physician

Printed Name of Physician

Address

City/State/Zip

(_____) _____
Telephone Number

INSTRUCTIONS

Physician: Give one copy of the completed form to the Worker.
Send another copy of the completed form to:
Clerk of the Court
Workers' Compensation Administration
PO Box 27198
Albuquerque, New Mexico 87125-7198

APPENDIX 4. WCA Approved Patient's Medical Release Form (English)

WORKER'S AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR WORKERS' COMPENSATION PURPOSES (HIPAA COMPLIANT)

I, (Print Worker's Name) _____ hereby authorize the health care provider (HCP) - (the name of HCP is optional and not required for release of medical information) (Print Health Care Provider's Name) _____ the use or disclosure of my health information as described in this authorization.

1. INFORMATION

WCA No. _____

Date of Birth: _____ Date of Injury: _____ SSN: _____

Address: _____ Phone: _____

Worker's representative, if any: _____ Phone: _____

Address: _____

2. RELEASE

I authorize the Health Care Provider (HCP) or any member or employee of its office or association who has examined or treated me, as well as any hospital or treatment facility in which I have been a patient, to disclose and release complete and legible copies of any and all information concerning my physical or psychiatric condition, care and treatment, to my employer, _____, and /or its insurance carrier, _____, and/or their attorneys, and/or duly authorized representatives of the New Mexico Workers' Compensation Administration and its current medical cost containment contractor or their duly authorized agents. Copies of all documentation released pursuant to this authorization shall be sent to the agency requesting the information and to me or my representative as listed above.

3. I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: medical reports; clinical notes; nurses' notes; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; hospital bills; bills for services the HCP has rendered; payments received; and any other relevant and material information in the HCP's possession. This Authorization also includes, if applicable, any hospital operational logs, emergency logs, tissues committee reports, psychiatric reports and records, physical therapy records, and all outpatient records. This release may also be used to request a Form Letter to HCP as approved by the Workers' Compensation Administration. I understand that I have the right to restrict the information that may be provided by signing this authorization to the extent provided by law.

CONDITIONS

4. I understand the purpose of this request is to determine the proper level of workers' compensation benefits and may include information regarding any of the following: to determine my occupational injury or illness status; to determine my eligibility for workers' compensation benefits; to determine my current and future medical status after occupational injury; to determine my current medical status and/or return-to-work capability.

11.4.4 NMAC

Rev. 2007

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying the company named in Paragraphs 1 and 2. I understand that the revocation is only effective after it is received and logged by that company and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I further understand that my revocation of this authorization may affect my ability to receive occupational injury or workers' compensation benefits governed by this revocation.

6. I understand that after this information is disclosed, the recipient may continue to use it pursuant to my prior authorization, regardless of my subsequent revocation of this authorization. I further understand that different protections may be available pursuant to state and federal law.

7. I understand that information to be released pursuant to a work-related/occupational injury or illness/workers' compensation claim may also be released to WCA and its current medical cost containment contractor or their duly authorized agents.

8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of six (6) months from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and a representative of my employer, its attorney or insurance carrier to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting A copy of this authorization _____ Yes _____ NO - If Yes, I have received a copy _____ (initial).
I understand this authorization will expire within six (6) months of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

Signature of Employee: _____ Date _____

Personal Representative Section:

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation):

Signature of Personal Representative: _____ Date: _____

APPENDIX 5. WCA Approved Patient's Medical Release Form (Spanish)

AUTORIZACIÓN DEL TRABAJADOR PARA LA REVELACIÓN DE INFORMACIÓN MÉDICA PRESERVADA PARA PROPÓSITOS DE LA COMPENSACIÓN A LOS TRABAJADORES (EN CONFORMIDAD CON HIPAA)

Yo, (imprima el Nombre del Trabajador) _____, por este medio autorizo al proveedor de atención médica (PAM) – (el nombre del PAM es opcional y no se requiere para revelar la información medica) (Imprima el nombre del Proveedor de Atención Médica) _____ el uso o revelación de mi información médica descrita en esta autorización.

1. **INFORMACIÓN** WCA Núm. _____

Fecha de Nacimiento _____ Fecha de la lesión _____ SSN _____

Dirección: _____ Teléfono: _____

Representante del Trabajador (si lo hay) _____ Teléfono: _____

Dirección: _____

2. **EMISIÓN**

Yo autorizo al Proveedor de Atención Médica o a cualquier miembro o empleado de su oficina o asociación que me haya consultado o atendido, y de igual manera a cualquier hospital o centro de tratamiento en el cual he sido atendido, para que proporcione y revele copias legibles de cualquier y toda la información concerniente a mi condición física y siquiátrica, de la atención y tratamiento, a mi empleador, _____, y/o su compañía de seguros, _____, y/o sus abogados y a los representantes debidamente autorizados de la Administración para la Compensación a los Trabajadores y a su actual contratista de la contención del costo médico o sus debidos agentes autorizados. Copias de todos los documentos emitidos conforme a esta autorización deberán ser enviados a la agencia que está requiriendo la información y a mí o a mi representante como se menciona anteriormente.

3. Yo entiendo que la siguiente información será publicada seguida a una reclamación de la compensación a los trabajadores por una lesión o enfermedad ocupacional relacionada al trabajo: informes médicos, apuntes clínicos, apuntes de enfermería, el historial de lesiones del paciente, quejas objetivas y subjetivas del paciente, radiografías, los resultados de análisis y reconocimiento, interpretación de radiografías y otros análisis (incluso una copia del informe); diagnosis y prognosis, recibos de pago del hospital, recibos de pago para consultas y tratamientos por el proveedor de atención médica, recibos del pago efectuado, y cualquier información pertinente y esencial que tenga en su poder el proveedor de atención medica. Esta autorización también incluye, en caso de ser aplicable, lo siguiente: cualquier diario de operaciones del hospital, diarios de urgencias, informes de los comités de tejidos, informes y constancias siquiátricas, constancias de terapia física y toda constancia de tratamiento de paciente externo. Esta autorización se puede usar para pedir la carta oficial al proveedor de atención médica (Form Letter to Health Care Provider), que ha sido aprobada por la Administración para la Compensación a los Trabajadores. Entiendo que tengo el derecho a limitar la información que pueda ser proporcionada al firmar esta autorización para tal efecto provisto por la ley.

CONDICIONES

4. Yo entiendo que el propósito de este requerimiento es para determinar el nivel preciso de beneficios de compensación a los trabajadores y que puede incluir información con respecto a lo siguiente: para determinar mi

estado de enfermedad ocupacional o lesión; para determinar mi elegibilidad a los beneficios de compensación a los trabajadores; para determinar mi estado médico presente y futuro después de una lesión ocupacional; para determinar mi estado médico actual y/o la capacidad para regresar al trabajo.

5. Derecho a revocar: Yo entiendo que tengo el derecho de revocar esta autorización a cualquier hora notificando a la compañía mencionada en los párrafos 1 y 2. Entiendo que la revocación es únicamente efectiva después de ser recibida y registrada por esa compañía y que cualquier uso o revelación hecha antes de la revocación bajo esta autorización no será afectada por la revocación. Sobrentiendo que mi revocación a esta autorización puede afectar mi habilidad para recibir beneficios por lesiones ocupacionales o de compensación a los trabajadores regida por esta revocación.

6. Yo entiendo que después de que esta información sea revelada, el receptor puede continuar usándolo ejerciendo mi autorización anterior, sin importar mis revocaciones subsecuentes a esta autorización. Sobrentiendo que protecciones diferentes pueden estar disponibles conforme a la ley estatal y federal.

7. Yo entiendo que la información a ser publicada de acuerdo con una lesión o enfermedad ocupacional/relacionada con el trabajo/reclamo de la compensación a los trabajadores puede también ser revelada a la Administración para la Compensación a los Trabajadores y a su actual contratista de la contención del costo médico, o sus agentes debidamente autorizados.

8. Por este medio renuncio cualquier regulación y/o reglas de ética que pueda de otra manera prevenir a cualquier hospital o proveedor de la salud u otras personas que me han atendido o examinado en una capacidad profesional de revelar dichos apuntes.

9. Una fotostática u otra copia de este documento, el cual contiene mi firma, deberá ser considerada tan efectiva y válida como el original, y deberá ser aceptada por aquellos que se les envía o proporciona por un periodo de seis (6) meses de la fecha en que fue firmada.

10. Este documento no autoriza ninguna conferencia personal o telefónica o correspondencia directa entre ningún proveedor de la salud y un representante de mi empleador, su abogado o compañía de seguros para discutir mi caso y es únicamente para la publicación de documentación médica como se explica en el presente documento. Se permite únicamente una comunicación breve con el propósito limitado de obtener información médica.

11. Yo entiendo que tengo derecho a una copia de esta autorización y a cualquier documento que se haya proporcionado en esta autorización. Estoy pidiendo una copia de esta autorización Sí No – Si es sí, yo he recibido una copia (inicial). Entiendo que esta autorización terminará en seis (6) meses de la fecha de que la firmé, a menos que yo la revoque antes, siguiendo a lo que se dice en el párrafo 5.

Firma del Trabajador _____ Fecha _____

Sección del Representante Personal:

Si un representante personal ejecuta esta forma, ese representante dispone que él o ella tenga la autorización para firmar esta forma en base de (imprima las bases detalladas para la representación).

Firma del Representante personal _____ Fecha _____

******ESTA FORMA NO ESTÁ APROBADA POR EL DIRECTOR DE WCA Y SE PUEDE USAR SOLAMENTE COMO GUÍA PARA COMPLETAR LA AUTORIZACIÓN EN INGLÉS. WCA NO PERMITE ACEPTAR SU AUTORIZACIÓN USANDO ESTA FORMA******

APPENDIX 6. Optional forms for the Emergency Room and Physician's Office

The forms in this section are NOT mandatory. They are provided as a convenience to you.

This appendix contains:

Instructions for Emergency Rooms and Urgent Care Centers
Referral for follow-up care under workers' compensation

For Primary Care Physician Offices
Checklist for first office visit of patient under workers' compensation

For Treating Providers, Ombudsman contact information letters,
English and Spanish

This is a memo that you may copy and give to patients, advising the patient how to contact an ombudsman at the WCA. You may wish to copy this memo, add your name to the "From" line, and make additional copies which can then be given to your patients.

You may also wish to copy the list of WCA offices and telephone numbers, from the last page of this book to give to your patients with the memo.

For Treating Providers, Return to Work and Status Report forms
There are two forms, providing a choice of your preferred style.
Narrative style form
Checklist style form

These forms are for your use or to adapt as you wish. If you prefer to use the narrative style, you may also wish to refer to the checklist as a reminder of common work restrictions.

Emergency rooms and urgent care centers

(This page may be posted as a flier)

REFERRALS FOR FOLLOW-UP CARE UNDER WORKERS' COMPENSATION

If you plan to refer this patient for follow-up care:

Advise the patient to check with his employer before keeping the appointment

OR

to call an ombudsman at the New Mexico Workers' Compensation Administration before keeping the appointment.

The patient's employer may have a preferred health care provider for injuries covered under workers' compensation.

New Mexico workers' compensation law provides patients with certain rights regarding the selection of health care provider. By referring the patient for follow-up care, *you may be "using up" this patient's selection right.*

The patient should have the opportunity to be informed about the employer's preference for post-emergency care. The patient should contact the employer for instructions. In addition, the patient may:

- contact an ombudsman at the Workers' Compensation Administration; call 1-866-WORKOMP or 1-866-967-5667; or the nearest WCA office.
- read the health care provider selection information in the WCA's *Workbook for Injured Workers*, if you have a copy of it;
- read Booklet B-4 in the WCA booklet series *The Workers' Compensation Handbook for New Mexico*, explaining health care provider selection. This booklet is available online at www.workerscomp.state.nm.us under Booklets.

RETURN TO WORK

The physician may authorize the patient to return to work as soon as it is medically safe to do so, with temporary work restrictions if necessary. Provide clear written instructions regarding work restrictions.

Primary Care Physician Offices

Checklist for first visit to primary care physician under New Mexico workers' compensation

This checklist is provided to assist the physician and the office staff if you are not familiar with workers' compensation. These suggestions are not intended to replace your standard procedures if you have them.

The physician and the administrative staff will need the following information. If the patient cannot answer these questions, you may either require the patient to get this information from the employer or call the employer yourself.

Is this a work-related injury?

Have you reported this accident to your employer?

Do you have contact information: name and phone number of employer; name of person in authority to whom the accident was reported.

Do you have information about the insurance that will cover this?

Health Care Provider Choice questions:

Did your employer instruct you to come to this office;

OR

Did your employer tell you to select your own doctor;

OR

Did you not receive any instruction?

Does your employer have a posted notice telling employees which doctor to see if they have a work-related accident?

If you intend to treat this patient:

Assign the patient "homework" of

providing your office with employer/ insurer contact information for billing purposes;

providing you with written job description information (whether written by the patient or obtained by the patient from the employer) so that you can assess the patient's return-to-work options.

If you do not intend to treat this patient for this injury:

The patient may have selected you under the health care provider selection provision of the workers' compensation law. *If you refer the patient to another medical practice, you may be "using up" this patient's selection right.*

The patient should have a chance to decide what to do. The patient may:

- contact an ombudsman at the Workers' Compensation Administration; call 1-866-WORKOMP or 1-866-967-5667; or the nearest WCA office.
- read the health care provider selection information in the WCA's *Workbook for Injured Workers*, if you have a copy of it;
- read Booklet B-4 in the WCA booklet series *The Workers' Compensation Handbook for New Mexico*, explaining health care provider selection. This booklet is available online at www.workerscomp.state.nm.us under Booklets and may be downloaded.

MEMO TO MY PATIENT

From: _____

To: _____

It will be helpful to you to have more information about your workers' compensation claim.

The Workers' Compensation Administration, an agency of the State of New Mexico, has helpful information for you.

The WCA has a group of staff members called ombudsmen, who are waiting to help you. They are specialists in understanding the workers' compensation system. You can talk to them in person or on the phone. They will help you to understand how the system works and how it affects you and your claim.

To reach an ombudsman by telephone, call this number. This is a free telephone call from anywhere in New Mexico.

1-866-WORKOMP / 1-866-967-5667

Or you can go to the nearest office of the Workers' Compensation Administration. There are offices in Albuquerque, Farmington, Las Cruces, Las Vegas, Lovington, Roswell and Santa Fe. I am providing you with a copy of all the addresses and telephone numbers.

The Workers' Compensation Administration publishes books that have information specially for injured workers. You can get those books by calling the WCA on the telephone or by going in person.

MEMO A MI PACIENTE

DE: _____

PARA: _____

Le será provechosa tener más información sobre la administración de compensación de los trabajadores acerca de su reclamación. La Administración de Compensación de los Trabajadores (ACT), una agencia del estado de Nuevo México, tiene información provechosa para usted. La ACT tiene un grupo de miembros del personal llamados los *ómbudsmen* que están esperando para ayudarle. Son especialistas en entender el sistema de la compensación de los trabajadores. Usted puede hablarles en persona o por teléfono.

Le ayudarán comprender como funciona el sistema y como le afectará a usted y a su reclamación.

Para hablar con un *ómbudsman* por teléfono, llame este número telefónico. Esta es una llamada gratis.

1-866-WORKOMP
1-866-967-5667

Usted también puede visitar la oficina de la ACT. Hay oficinas en Albuquerque, Santa Fe, Las Vegas, Lovington, Farmington, Las Cruces, y Roswell. Le proveo una copia de todas las direcciones y los números telefónicos de las oficinas.

La ACT publica los libros que tienen información especial para los trabajadores lesionados. Se puede conseguir esos libros llamando a la ACT por teléfono o haciendo una visita para la ACT en persona.

Physician's Work Release Report

PHYSICIAN NAME: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE INJURED: _____ DATE EXAMINED: _____

After examination/treatment, I recommend the following:

- Return to work on: _____
- Do not return to work until further notice; return for appointment on _____.
- Return to restricted work (see below):
- Return to restricted work (ALSO see physician's narrative on separate page):
- When will Maximum Medical Improvement (MMI) be anticipated? _____

WORK RESTRICTIONS

- None
- No motor vehicle operation
- No working around dangerous machinery
- No ladder climbing
- No working at elevations
- No pole climbing
- No working alone for prolonged periods
- No excessive walking or standing
- No squatting or bending
- No exposure to extreme weather
- No work in areas with loud noise
- No work requiring good hearing
- No use left/right upper extremity
- No out-of-body reaches > 12'
- No work with arms above head
- No exposure to chemicals/irritating inhalants
- No work needing excessive eye use or depth perception

LIFTING, WALKING, STANDING RESTRICTIONS

Sedentary Work: Patient may lift up to 10 pounds occasionally or up to 5 pounds frequently. A job is in this category if walking and standing are required only occasionally and other sedentary criteria are met.

Light Work: Patient may lift up to 20 pounds occasionally or up to 10 pounds frequently. A job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm or leg controls or both

Medium Work: Patient may lift up to 50 pounds occasionally or up to 25 pounds frequently

Heavy Work: Patient may lift over 50 pounds occasionally or up to 50 pounds frequently.

1. Work Limited to _____ hours/day

2. In a given work day, patient may not exceed:

Stand/Walk None 4-6 Hours 1-4 Hours 6-8 Hours

Sit 1-3 Hours 3-5 Hours 5-8 Hours

Drive 1-3 Hours 3-5 Hours 5-8 Hours

3. Patient may not use hands for repetitive:

Grasping/gripping Pushing/Pulling

Fine Manipulation Key stroking

4. Patient is limited to:

	Continuous	Frequently	Occasionally
a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This form is provided by the New Mexico Workers' Compensation Administration as a convenience for the physician and the parties. It is optional and may be modified to suit the preferences of the parties.

APPENDIX 7. Demand for Notice of Contested Billing, Form and Instructions

See the “Billing and Payment” section for use of this form.

Instructions:

1. Part A is to be completed by the Practitioner.
2. The Practitioner will mail the original to the employer/payer.
3. Part B is to be completed by the employer/payer.
4. The employer/payer will mail the response to the Practitioner.
5. **DO NOT** send a copy to the WCA unless it is in conjunction with a request for a Director’s Determination.
6. Time frames must be in compliance with 11 NMAC 4.7.13.1.
This is in Part 7 of the WCA rules; if you do not have a current copy of the Rules, you can access this on the WCA web site at www.workerscomp.state.nm.us. Look for “Rules and Regulations” and open Rules Part 7. Scroll down to:

11.4.7.13 BILLING AND PAYMENT DISPUTE RESOLUTION

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

HEALTH CARE PRACTITIONER'S
DEMAND FOR NOTICE OF CONTESTED BILLING

PART A

Health Care Practitioner: _____

Mailing Address: _____

Telephone: _____

Date(s) of Service: ____/____/____ through ____/____/____

Date of Injury: ____/____/____

Total Billing Amount: \$ _____

Worker's Name: _____

Social Security Number: ____ - ____ - ____

Employer: _____

Payer's Name: _____

(Indicate whether payer is Insurance Carrier () or Self Insured () or TPA ())

I hereby certify that a copy of the foregoing Demand was mailed to the payer and the
employer on the _____ day of _____, 200____.

Health Care Practitioner's Signature

Date

Subsection A (1) of 11.4.7.13 NMAC
(Revised 10/25/02)

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

PAYER'S RESPONSE TO DEMAND FOR NOTICE OF CONTESTED BILLING

PART B

Payer's Name: _____

Health Care Practitioner: _____

Worker's Name: _____

Social Security Number: _____ - _____ - _____

Check 1 or 2:

1. (___) Compensability of Claim Denied for the following reason: _____

2. (___) Compensability Acknowledged by bill(s) Contested (entire bill _____ or
portion of bill _____) for the following reasons: _____

3. The following amount has been paid on any non-contested portion of the bill(s):

\$ _____ Date paid: _____

I hereby certify that a copy of the foregoing response was mailed to the Health Care
Practitioner and employer on the _____ day of _____, 200____.

(Name of Payer)

(Signature)

Subsection A (1) of 11.4.7.13 NMAC
(Revised 10/25/02; modified 9/05)

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

STATE HEADQUARTERS

Mailing Address: Workers' Compensation Administration

PO Box 27198, Albuquerque NM 87125

Location: 2410 Centre Avenue SE (near Yale-Gibson intersection)

In-state toll-free phone: 1-800-255-7965

Local phone 841-6000

REGIONAL OFFICES:

Southeastern regional office at Lovington:

100 West Central, Lovington, NM 88260

Telephone: 575-396-3437

In-state toll-free phone: 1-800-934-2450

Southwestern regional office at Las Cruces:

1120 Commerce Drive, Suite B-1, Las Cruces, NM 88011

Telephone: 575-524-6246

In-state toll-free phone: 1-800-870-6826

Northwestern regional office at Farmington:

3535 East 30th Street, Farmington, NM 87401

Telephone: 505-599-9746

In-state toll-free phone: 1-800-568-7310

Northeastern regional office at Las Vegas :

2515-2 Ridge Runner Road, Las Vegas NM 87701

Moving in 2008 to: 32 New Mexico 65, Las Vegas NM 87701

Telephone: 505-454-9251

In-state toll-free phone: 1-800-281-7889

Roswell Office:

Penn Plaza Bldg., 400 N. Pennsylvania Ave., Ste. 425, Roswell NM 88201

Telephone: 575-623-3781

In-state toll-free phone: 1-866-311-8587

Santa Fe Office:

810 West San Mateo, Suite A-2, Santa Fe, NM 87505

Telephone: 505-476-7381

Internet web site address: <http://www.workerscomp.state.nm.us/>

HELP & HOTLINE: 1-866-WORKOMP / 1-866-967-5667

mjdwca 1/08



New Mexico Workers' Compensation Administration