

*New Mexico*  
*Workers' Compensation Administration*

**Recommended Forms and  
Sample Worksheets**

*Bill Richardson*  
*Governor*

*Glenn R. Smith*  
*Director*

**WORKERS' COMPENSATION  
RATIO REPORT WORKSHEET**

Hospital/FASC: \_\_\_\_\_ Federal Tax ID No: \_\_\_\_\_

City: \_\_\_\_\_ Medicare Provider No: \_\_\_\_\_

Fiscal Year Ending: \_\_\_ / \_\_\_ State ID. Tax No: \_\_\_\_\_  
(mo) (yr)

The ratio is calculated by the formula:

$$\text{WC Ratio} = \frac{\text{Adjusted Operating Expenses}}{\text{Adjusted Net Revenue}}$$

**A. ADJUSTED NET REVENUE (ANR) IS DERIVED AS FOLLOWS:**

- |           |  |                 |
|-----------|--|-----------------|
| 1.        | Total Patient Revenues   | \$ _____        |
| 2.        | Deductions from Revenues   |                 |
| a.        | Uncompensated Care (charity & bad debt)  | \$ _____        |
| b.        | Medicare Contractual Allowances  | \$ _____        |
| c.        | Medicaid Contractual Allowances  | \$ _____        |
| d.        | Other Governmental Contractual Allowances (attach itemized schedule)                         | \$ _____        |
| e.        | Total Deductions from Revenues (Subtotal lines a. through d.)                                | (\$ _____)      |
| 3.        | Total Patient Revenues Minus Total Deductions from Revenues (Line 1 minus line 2.e.)         | \$ _____        |
| 4.        | Other Operating Revenues (mill levies/government subsidies/etc., excludes investment income) | \$ _____        |
| 5.        | Physician Professional Fees  | (\$ _____)      |
| <b>6.</b> | <b>Adjusted Net Revenue (ANR)</b><br>(Sum of A.3. plus A.4. minus A.5.)                      | <b>\$ _____</b> |

**B. ADJUSTED OPERATING EXPENSE (AOE) IS DERIVED AS FOLLOWS:**

- |           |   |                 |
|-----------|---|-----------------|
| 1.        | Total Operating Expenses  | \$ _____        |
| 2.        | Related Organizational Expenses   | \$ _____        |
| 3.        | Physician Expenses  | \$ _____        |
| <b>4.</b> | <b>Adjusted Operating Expenses (AOE)</b><br>(Before Income Taxes)<br>(Sum of B.1. plus B.2. minus B.3.) | <b>\$ _____</b> |

**C. DATA COLLECTION**

- 1. Other Allowances
  - a. Non-governmental contracts \_\_\_\_\_
  - b. All other - please itemize \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 2. Accrued Gross Revenues from Workers' Compensation \_\_\_\_\_  
Accrued Net Revenues from Workers' Compensation \_\_\_\_\_

- 3. Aggregate percentage charge increase(s) and effective date(s), if any, that have been implemented during the fiscal year reported.

**D. CERTIFICATION**

I hereby certify that to the best of my knowledge and belief this is a true, correct and complete statement prepared from the books and records of the hospital.

\_\_\_\_\_  
Prepared by Title Date

\_\_\_\_\_  
Phone Number Officer's Signature Date

**AGENCY USE ONLY**

Hospital: \_\_\_\_\_ Date Received: \_\_\_\_\_

Calculated Hospital WC Ratio = AOE \$ \_\_\_\_\_ + ANR \$ \_\_\_\_\_ = \_\_\_\_\_

Assigned Hospital WC Ratio = \_\_\_\_\_ (Not lower than .80 or greater than 1.00)

\_\_\_\_\_  
Workers' Compensation Administration  
Staff Reviewer (Signature)

\_\_\_\_\_  
Date

**STATE OF NEW MEXICO  
WORKERS' COMPENSATION ADMINISTRATION  
FISCAL YEAR (FY) REPORTING FORM**

HOSPITAL/FASC NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

CURRENT FY: \_\_\_\_\_ NEW FY: \_\_\_\_\_

OFFICER/ADMINISTRATOR: \_\_\_\_\_  
(Print Name and Title)

\_\_\_\_\_  
(Signature) (Date)

**Note:** This form must be completed and submitted immediately upon any change in the hospital's or FASC's fiscal year.

SUBMIT TO:           Workers' Compensation Administration  
                          Medical Cost Containment Bureau  
                          P.O. Box 27198  
                          Albuquerque, NM 87125-7198

## **DEMAND FOR NOTICE OF CONTESTED BILLING 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 in conjunction with a request for a Director's Determination.
6. **Time frames must be in compliance With 11 NMAC 4.7. 13.1.**

**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

**RESPONSE TO DEMAND FOR NOTICE OF CONTESTED BILLING**

**PART B**

**Check 1 or 2:**

1. (\_\_\_\_) Compensability of Claim Denied for the following reason:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. (\_\_\_\_) Compensability Acknowledged but bill(s) Contested (entire bill \_\_\_\_\_ or portion of bill \_\_\_\_\_) for the following reasons:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. The following amount has been paid on any con-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)