# New Mexico Workers' Compensation Administration

# Fee Schedule

# and

# Billing Instructions

*Effective: December 31, 2013*

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Susana Martinez
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# BILLING INSTRUCTIONS

## Referrals and Consultations

If an initial consultation was already completed by a provider and that same provider is now being referred to and will manage all or part of the patient's care, the following shall apply:

| SHALL BE USED | SHALL NOT BE USED |
|---|---|
| Evaluation and Management Codes<br>Only Established Patient Codes | Follow-up consultation codes |

If a provider, who has been requested to examine a patient, assumes immediate responsibility for primary care of a patient, it shall be considered a referral and not a consultation; the following shall apply:

1. Consultation codes ***shall not*** be used.
2. Evaluation and management codes ***shall*** be used.
3. ***For the first visit only***, a new patient code may be used.
4. HCPs and caregivers ***may*** negotiate with the payer, ***prior*** to performing the service, regarding the use of consultation codes in appropriate circumstances.

When the care of a patient is referred to a different provider, the referring provider must submit pertinent medical records, including imaging, as requested. The records are to be provided at no charge to the patient, the new provider and/or the payer.

## New Mexico Gross Receipts Tax (NMGRT)

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

1. On the billing form next to the "total charges," print or stamp "*NMGRT Included*" along with the appropriate tax rate percentage.
2. If *"NMGRT Included"* is not noted on the billing form, the bill will be paid either according to the Health Care Providers' Fee Schedule or the billed amount applicable to the provider, whichever is less.
3. Below the "total charges," add the NMGRT amount, listing the appropriate tax rate percentage. Add this amount to the "total charges" to derive a *"total amount billed*."

## Completion of Billing Forms

"WORKERS' COMPENSATION" or "WORK COMP" must be printed or stamped at the top of each billing form. If a subsequent billing (or a copy of the original bill) is sent for the same service(s), it must be labeled "*TRACER*" or "*TRACER BILL*."

The following forms, as adopted from the Centers for Medicare & Medicaid Services (CMS), are used to file New Mexico Workers' Compensation Claims and must include patient identification and appropriate information. For each procedure billed, the appropriate CPT code and descriptor must be included, regardless of which form is used. Implementation of Form CMS-1500 (02/12) shall coincide with Medicare's timeline.

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

Form UB-04 CMS-1450 is used to bill for services where the ratio discount method is used. This includes inpatient services, emergency room services and hospital outpatient surgery.

Hospitals who calculate their services according to the Health Care Providers' Fee Schedule can use either form CMS-1500 or UB-04 CMS-1450.

Free-Standing Ambulatory Surgery Centers (FASCs) are to bill for services using Form CMS-1500. In addition to FASCs, Form CMS-1500 is also used for all outpatient services whose fees are calculated according to the Health Care Providers' Fee Schedule.

Pharmaceutical billings ***do not*** require a specific form.

# INSTRUCTIONS FOR COMPLETING FORMS

## Form CMS-1500 (02/12)

The following information outlines what billing information is to be included and where it is to be placed when billing on a CMS-1500 (02/12) claim form. Bills must contain the information as outlined below:

**Item Number 1.** Place an "X" in the "Other" box.

**Item Number 1a.** Enter the patient's Social Security number.

**Item Number 2:** Enter the patient's full last name, first name and middle initial. Periods are not allowed within the field; however, commas and hyphens may be used.

**Item Number 3.** Enter the patient's 8-digit birthdate (MM|DD|YYYY). Enter an X in the correct box to indicate gender of the patient.

**Item Number 4.** Enter the name of the Employer.

**Item Number 5.** Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

**Item Number 6.** Omit.

**Item Number 7.** Enter the address of the Employer. If required by a payer to report a telephone number, do not use a hyphen or space as a separator within the telephone number.

**Item Number 8.** Omit.

**Item Numbers 9, 9a-9d.** Omit.

**Item Numbers 10a-10c.** Mark appropriate box(es) with an "X". The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident."

**Item Number 10d.** Condition Codes are required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these conditions). *NOTE*: Do not use Condition Codes when submitting a revised or corrected bill.

**Item Number 11.** Enter the name of the workers' compensation insurance carrier, self-insured employer or third party administrator.

**Item Number 11a-11d.** Omit.

**Item Number 12.** Omit.

**Item Number 13.** Omit.

***Anesthesia and Laboratories may omit Item Numbers 14, 15 and 16.***

**Item Number 14.** Enter the 6-digit (MM|DD|YY) date of the work-related accident or the first symptoms of the work-related illness.

**Item Number 15.** Complete if appropriate. Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported:

454 Initial Treatment
304 Latest Visit or Consultation
453 Acute Manifestation of a Chronic Condition
439 Accident
455 Last X-ray
471 Prescription
090 Report Start (Assumed Care Date)
091 Report End (Relinquished Care Date)
444 First Visit or Consultation

Enter the qualifier between the left-hand set of vertical, dotted lines.

**Item Number 16.** If the patient is unable to work in current occupation, a 6-digit (MM|DD|&&) or 8-digit (MM|DD|YYYY) date must be shown for the "from-to" dates that the patient is unable to work.

**Item Number 17.** Enter the name (First, MI, Last) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies). If multiple providers are involved, enter one provider using the following order: 1. Referring Provider (qualifier DN), 2. Ordering Provider (qualifier DK), 3. Supervising Provider (qualifier DQ). Do not use periods or commas; a hyphen can be used. Enter the qualifier to the left of the vertical, dotted line.

**Item Number 17a.** Omit.

**Item Number 17b.** Enter the National Provider Identifier (NPI) number of the referring, ordering, or supervising provider.

**Item Number 18.** If applicable, enter the inpatient 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date. If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of , or subsequent to, a related hospitalization.

**Item Number 19.** Omit.

**Item Number 20.** Complete as appropriate.

**Item Number 21.** Enter the applicable *International Classification of Diseases* (ICD) indicator to identify which version of ICD codes is being reported: (9 = ICD-9-CM; 0 = ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9 CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

**Item Number 22.** List the original reference number for resubmitting claims. Please refer to the most current instructions from the payer regarding the use of this field (e.g., code). When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. (7 = Replacement of prior claim; 8 = Void/cancel of prior claim.) This Item Number is not intended for use for original claim submissions.

**Item Number 23.** Omit.

**Item Number 24A** (Lines 1-6). Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From". Leave "To" blank or re-enter "From" date.

**Item Number 24B.** Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf.

**Item Number 24C.** Omit.

**Item Number 24D**. Enter the CPT code(s) and modifier(s) if applicable, from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description.

**Item Number 24E.** Enter the diagnosis code reference letter as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-9-CM diagnosis codes must be entered in Item Number 21 only; do not enter them in 24E.

**Item Number 24F.** Enter the charge for each listed service. Enter the number right-justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

**Item Number 24G.** Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the number 1 must be entered.

**Item Number 24H.** Omit.

***Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.***

**Item Number 24I.** If the provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. (0B=State License Number; 1G = Provider UPIN Number; G2 = Provider Commercial Number; LU = Location Number; ZZ = Provider Taxonomy.) The Other ID# of the rendering provider should be reported in 24J in the shaded area.

**Item Number 24J.** The individual performing/rendering the service is listed in 24J and the qualifier indicating if the number is a non-NPI is reported in 24I. The non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional**.**

**Item Number 25.** Enter the Provider's "Federal Tax ID Number" of the Billing Provider identified in Item Number 33. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. Do not enter hyphens with numbers. Enter numbers left justified in the field.

**Item Number 26.** Optional; Enter the patient's account number assigned by the provider. Do not use hyphens with numbers. Enter numbers left justified in the field.

**Item Number 27.** Omit.

**Item Number 28.** Enter total charges for the services (i.e., total of all charges in 24F). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

**Item Number 29.** This section may be used to indicate any agreed upon discount amount or rate.

**Item Number 30.** Omit.

**Item Number 31.** Enter the signature of the practitioner or supplier or their representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|YYYY), or alpha-numeric date that the form was signed. In addition, provide degree, credentials or title as appropriate.

**Item Number 32.** Use the following format to enter the location where the services were rendered:

1st Line – Name of Service Facility
2nd Line – Address
3rd Line – City, State and ZIP Code

Do not use punctuation (i.e., commas and periods) or other symbols in the address. Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code, including the hyphen.

**Item Number 32a.** Enter the NPI number of the service facility location in 32.

**Item Number 32b.** Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number: (0B = State License Number; G2 = Provider Commercial Number; LU = Location Number).

**Item Number 33**. Enter the Provider's or supplier's billing name, physical billing address, ZIP code, and phone number as follows:

1st Line – Name of Provider
2nd Line – Address
3rd Line – City, State and ZIP Code

The phone number is to be entered in the area to the right of the field title.

**Item Number 33a.** Enter the NPI number of the billing provider in 33a.

**Item Number 33b.** Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number: (0B = State License Number; G2 = Provider Commercial Number; ZZ = Provider Taxonomy).

## Form UB-04 CMS-1450

The following information must be completed by Health Care facilities.

**Locator 1.** Provider name, complete address and telephone number.

**Locator 2.** Paid to service provider - name and address.

**Locator 3.** Patient control number, medical record number.

**Locator 4.** Enter code 111, 115, 117, 121, 125, 127, 851, 855, or 857 for inpatient; Code 131, 135, or 37 for outpatient and for emergency room; and 831 for FASC. (Note: if locator 42 contains an entry beginning with "45", then the service was emergency room, not outpatient.)

**Locator 5.** Hospital federal tax identification number.

**Locator 6.** Statement coverage dates must be provided.

**Locator 7.** (NM Specific) Covered days - the days during the billing period applicable to the cost report.

**Locator 8a.** Injured worker's Social Security Number.

**Locator 8b.** Injured worker's name.

**Locator 10.** Injured worker's birthdate.

**Locator 11.** Injured worker's gender.

**Locator 12.** Date of admission to hospital or facility.

**Locator 14.** Type of admission; code values: 1=Emergency, 2=Urgent, 3=Elective, 5=Trauma Center, 9 = information unavailable.

**Locator 15. S**ource of admission code values: 1=physician referral, 2=clinic referral, 3=HMO referral, 4=hospital transfer, 6=transfer from HCF, 7=ER, 8=law enforcement, 9=unavailable, A=transfer from (CAH).

**Locator 17.** Patient status: code values (01-76).

**Locators 18-28.** Use condition code 02 for employment-related injury.

**Locator 29.** Two letter state abbreviation where accident occurred.

**Locator 31.** Occurrence code and date of work-related occurrence. Note: code = 02, 03, 04, 05, 06 or 07.

**Locator 37.** New Mexico WCA-specific DRG code (Diagnosis Related Group code used by Medicare to group medical services provided by inpatient hospital services). Required for type of bill = 111, 115, 117,121, 125, 127 or inpatient for CAH codes 851, 855 and 857.

**Locator 42.** Revenue codes for services billed. (Note: revenue code (0001) must be provided in column 42 for total charges.)

**Locator 43.** Lists and describes each medical service and item being billed corresponding to applicable revenue code.

**Locator 44.** Accommodation rate for applicable services provided.

**Locator 46.** Units of service (mandatory for accommodation rate).

**Locator 47.** Billed charges. Information based on service provided (revenue code). (Note: last revenue code in column 42 must be 0001).

**Locator 50.** Insurance carrier, self-insurer or TPA (claims administrator).

**Locator 56.** National provider identifier of hospital facility.

**Locator 58.** Insured's name or employer's name.

**Locator 60.** SSN of injured worker or worker's identification number.

**Locator 63.** WCA authorization number, if applicable.

**Locator 65.** Employer's name.

**Locator 67.** Principle diagnosis code must be based on ICD-9-CM or the most recent version of the ICD required by CMS. Code must include all digits.

**Locator 67a-h.** Other diagnosis codes are based on ICD-9-CM or the most recent version of the ICD required by CMS. These codes are sent to payer if available.

**Locator 72.** External cause of injury code.

**Locator 73.** (NMWCA-specific) The health care facility's current workers' compensation ratio.

**Locator 74 and 74 (a-e).** Principle procedure code and date: The HCP enters the ICD-9-CM code or the most recent version of the ICD required by CMS for the inpatient principle procedure. The principle procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, which is necessary to take care of a complication. The code should relate closely to the principle diagnosis. A date should also be provided.

# EXPLANATION OF BENEFITS (EOBs)

## Standard EOBS

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

EOB-01 ***Claim not compensable***. The compensability of this workers' compensation claim has been denied by the employer or payer.

EOB-02 ***Services are not reasonable and necessary***. This service/procedure/item is not considered reasonable or necessary for the compensable problem.

EOB-03 ***Incomplete billing information or supporting documentation***. The information/ documentation listed was not included with the bill. The charge(s) will be evaluated upon its receipt. Forward expeditiously.

## Inaccurate Billing/Billing Errors

EOB-04 ***This code is invalid***. It is not in the edition of the AMA's *Current Procedural Terminology* adopted in the director's annual order. Please code properly and resubmit.

EOB-05 ***This procedure was billed more than once on the same date***. (Indicate payment disposition.)

EOB-06 ***An identical bill for this claimant and date of service was previously submitted and paid, reduced, or denied***.

EOB-07 The code for this service has been changed to agree with the CPT code for this procedure in the governing version of the Health Care Providers' Fee Schedule.

EOB-08 ***The billed service is not substantiated by the medical notes***.

EOB-09 ***This code is already included in procedure code number___, which was billed on (date)***.

EOB-10 ***A new patient charge was made for this service without meeting the definition of "new patient" as found in the NMWCA's Billing Instructions and Health Care Providers' Fee Schedule***. Payment is commensurate with the established patient designation.

## Specific EOB reductions authorized by the NMWCA

EOB-11 ***This procedure/service was not provided by an authorized Health Care Provider (HCP)*** as specified in NMSA 1978, Section 52-4-1.

EOB-12 ***Payment has been reduced*** commensurate with the level of service documented in the medical records (including procedures with surgical modifiers).

EOB-13 ***Payment has been prorated*** for this procedure.

EOB-14 ***Payment has been reduced*** to the Health Care Providers' Fee Schedule, assigned hospital ratio, FASC amount, Pharm Maximum Allowable Payment (MAP) or the contracted or negotiated amount for this procedure or service.

EOB-15 ***This service was provided by a caregiver without an agreed upon fee***.

EOB-16 ***Professional fee at 40%*** of the Health Care Providers' Fee Schedule, ***technical fee at 60%*** of the Health Care Providers' Fee Schedule, or billed amount, whichever is less.

EOB-17 ***Medical records shall accompany each bill at no charge***.

# Fee Schedule

## Hospitals

The following services and items will be reimbursed as specified below:

Professional and technical charges for radiology, pathology and laboratory services shall be billed at rates equivalent to those set forth in the most current version of the Health Care Providers' Fee Schedule.

A detailed listing of the professional and technical services provided must be included and will be paid as set forth in the "*Service Component Modifiers: Radiology and Pathology/ Laboratory*" section found in this document.

## Free-Standing Ambulatory Surgery Centers

CPT codes submitted on Form CMS-1500 shall be paid according to the Centers for Medicare and Medicaid Services (CMS) Ambulatory Payment Classification (APC) as follows:

| | | |
|---|---|---|
| **APC Base Payment Rate** | **X** | **1.3** |

The APC can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospital OutpatientPPS/Addendum-A-and-Addendum-B-Updates.html/ under Addendum B. No adjusted conversion factors or index values are to be applied. If no assigned APC base payment rate is indicated, the services shall be paid 'BR'.

## Surgical Modifiers

### Bilateral Procedure: " -50 "

| | |
|---|---|
| ***First or Major Procedure*** (when performed during the same operative session) | Coded with the appropriate CPT code ***without*** a modifier. Paid at the lesser of billed charges or the Health Care Providers' Fee Schedule |
| ***Second Procedure*** | Coded with the same CPT code ***plus*** the " -50 " modifier code. Paid at no more than 50% of the Health Care Providers' Fee Schedule |

### Multiple Procedures: " -51 "

| | |
|---|---|
| ***Primary or Major Surgical Procedure*** | Coded with the appropriate CPT code ***without*** a modifier. Paid at the lesser of the billed charges or the Health Care Providers' Fee Schedule |
| ***Second and Third Procedure*** | Coded with the respective CPT code ***plus*** the "-51" modifier code and shall be paid at 50% of the Health Care Providers' Fee Schedule |
| ***Fourth and Subsequent Procedures*** | Paid BR |

### Assistant Surgeon: " -80 "

| | |
|---|---|
| ***Attending Surgeon*** | Shall bill using the appropriate CPT code(s) ***and modifiers, if applicable***, for the procedure(s) performed. Paid at the lesser of the billed charges or the Health Care Providers' Fee Schedule, subject to the percentages for modifiers in this section |
| ***Assistant Surgeon*** | Shall bill using the appropriate CPT code(s) ***plus the modifier*** for the procedures performed. Paid at no more than 25% of the Health Care Providers' Fee Schedule. |

## Implants, Hardware & Surgical Instrumentation

Any implants, hardware and instrumentation used during surgery shall be reimbursed as follows:

**Invoice cost X 1.25 + Shipping, handling and NMGRT**

## Anesthesia

The maximum allowable amount for the CPT code series 00100-01999 (which is specific to the field of anesthesia), shall be determined by including a monetary conversion factor of $53.07. This monetary conversion factor shall be multiplied by the basic unit value which equals the basic units added to the time units added to any modifiers regarding physical status or qualifying circumstances to determine the maximum allowable amount. The units need to be separate in this equation.

| Monetary Conversion Factor | | Basic Unit Value | | Maximum Allowable Amount |
|---|---|---|---|---|
| **($53.07)** | **X** | **(Basic Units + Time Units+ Modifier)** | **=** | |

The "basic unit value" assigned to each procedure in the CPT code series 00100-01999 in the *American Society of Anesthesiologists (ASA) Relative Value Guide* which has been adopted by the Director in his annual order shall be used when billing for anesthesia services.

"Time units" shall be recorded and billed in 15-minute increments and fractions of units rounded to the nearest fraction (1/15th) of a unit. For example, in a procedure that required 19 minutes of anesthesia time, the total value should be determined as follows:

19 minutes = 1 unit (15 minutes) + 4/15 of a unit (4 minutes)
1 unit = $53.07
1 minute = $53.07/15 = $3.54
$3.54 x 4 minutes = $14.16
19 minutes = $53.07 + $14.16 = $67.23

## Modifiers

**Physical Status**: The following six levels are consistent with the most current addition of the *ASA Relative Value Guide's* ranking of patient physical status. Physical status should be included in CPT to distinguish between various levels of complexity of the anesthesia service provided. Physical status modifiers are represented by the initial letter P followed by a single digit from 1 to 6 as defined below.

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



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

## Physical Medicine and Rehabilitation Services

New Mexico specific codes are no longer in use. Please consult the fee schedule currently in use for specific codes. Evaluation and management codes are not appropriate for this purpose.

Physical therapy bills may include all codes which are reasonable and necessary for the evaluation and treatment of a worker in a single day.

An initial failed appointment, without providing 48 hours' notice to the physical therapist, may be billed at 60% of the Health Care Providers' Fee Schedule.

## Durable Medical Equipment (DME)

Purchases of DME are paid as follows:

| | | | | |
|---|---|---|---|---|
| **Provider's Invoice Cost** | **+** | **25%** | **+** | **Taxes, Shipping & Handling** |

A copy of the invoice shall be provided either at the time of billing or upon the payer's request. All supplies and materials must be itemized.

Rental of DME shall not exceed 90 days unless it is determined by the payer to be more cost efficient to do so. Rental fees shall not exceed the cost of purchase established in the subparagraph, below. Rental fees paid for the first 30 days of rent may be applied against the purchase price. Subsequent rental fees may not be applied against the purchase price. The decision to purchase should be made within the first 30 days of rental.

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

## Evaluation and Management (E/M) Services

New Mexico has a unique definition of "new patient". The definition is also different from the one found in the CPT code book. E/M codes may not be prorated.

## Failed Appointments

A failed appointment by an established patient may not be billed.

An initial failed appointment, when the new patient fails to provide 48 hours' notice to the HCP, may be reimbursed using CPT Code 99202 and annotated as "FAILED INITIAL APPOINTMENT/ NEW PATIENT".

## Facility Fees

Charges for the use of a room, other than an emergency room visit or operating and recovery rooms, for inpatient or outpatient hospital surgery are prohibited.

For instances of outpatient services where two or more HCPs combine in delivery of the service, the maximum total payment is based on the Health Care Providers' Fee Schedule for the specific service. The HCPs may allocate the payment among themselves.

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

Second medical opinions requested by a party are deemed medically reasonable and necessary for payment purposes.

## Pharmacy

**Average Wholesale Price (AWP):**

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

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

- If an AWP listed in the publication is based on the exact quantity of the drug dispensed, e.g., #15, #60, 15 ml, 3.5 gm, etc., the AWP for the exact quantity shall be used with no prorating calculation made.

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

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

The formula for billing generic and brand name prescription drugs is:

**Pharm MAP($) = ($)AWP x .90 + $5.00**

The HCP formula for billing generic and brand name prescription drugs is:

**($)AWP x .90 (with no dispensing fee included)**

Pharmacies and authorized HCPs must include patient identification and information. No specific form is required.

Any bill that is submitted without a National Drug Code (NDC) number will be paid at the lowest AWP available for the month in which the drugs were dispensed.

## Materials and Supplies

Materials and supplies using CPT Code 99070 must be itemized and are reimbursed as follows:

| | | | | |
|---|---|---|---|---|
| **Provider's Invoice Cost** | **+** | **25%** | **+** | **Taxes Shipping & Handling** |

A copy of the invoice shall be provided either at the time of the billing or upon the payer's request.

## Service Component Modifiers: Radiology and Pathology/Laboratory

Use of the technical component (modifier code "-27") and professional component (modifier code "-26") is required for the billing of all radiology and pathology/laboratory procedures. The CPT code followed by "TC" is the appropriate billing code for the technical component.

The dollar value listed in the Health Care Providers' Fee Schedule for a specific radiology or pathology/laboratory procedure represents the combined maximum allowable amount for both the technical and professional components of that procedure.

| | |
|---|---|
| ***Technical*** component (when services are provided on an inpatient or outpatient basis) | Paid at no more than 60% of the Health Care Providers' Fee Schedule for the procedure |
| ***Professional*** component (inpatient or outpatient basis) | Paid at no more than 40% of the Health Care Providers' Fee Schedule for the procedure |

## DEFINITIONS

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

A. "ASA Relative Value Guide" means a document published by the American Society of Anesthesiologists (ASA) which includes basic relative unit values for each procedure code listed in the edition of the AMA's *Current Procedural Terminology* adopted in the Director's annual Order and unit values for anesthesia modifiers and qualifying circumstances. The current calendar year edition of the ASA *Relative Value Guide* applies.

B. "Authorized Health Care Provider (HCP)" means the Health Care provider selected in accordance with the Act.

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

D. By-report (BR) means a maximum amount for a service has not been established in the WCA Health Care Providers' Fee Schedule.

E. "Descriptor" means the definition of a service that is represented in the *Current Procedural Terminology* issued by the AMA.

F. "Failed appointment" means an appointment with a Health Care provider or caregiver for which the patient fails to show or arrives too late to be treated on the same day.

G. "Forms" means a bill for services that is rendered by a health care provider, caregiver, or supplier submitted on one of the following forms as outlined in this document:

   a. CMS-1500 (02/12)
   b. UB-04 CMS-1450 (OMB NO. 0938-0997)

H. "International Classification of Diseases (ICD-9-CM)" means a set of numerical diagnostic codes, 9th revision that is commonly referred to as ICD-9.

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

J. "Materials Supplied by a Health Care Provider (CPT Code 99070)" means supplies and materials over and above those usually included with the HCP's or caregiver's services and which are not governed by the durable medical equipment paragraph in this document. Examples include sterile trays, unit doses of drugs, bandages, elastic wraps, initial casting, splinting and strapping materials, removable splints, slings, etc.

K. "Maximum Allowable Amount" means the maximum amount reimbursed for any outpatient services, not including emergency department visits, outpatient surgery visits, or New Mexico Gross Receipts Tax.

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

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

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

O. “Service component modifiers (radiology and pathology/laboratory)” means the designation of radiology and pathology or laboratory procedures that are divided into professional and technical components for billing purposes.

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

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

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