State of New Mexico
WORKERS' COMPENSATION ADMINISTRATION

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Response to Public Comments Regarding the 2026 WCA Health Care Provider Fee Schedule and Billing Instructions ("HCP Fee Schedule")

The proposed changes ("proposed changes") to the existing 2025 HCP Fee Schedule were released for public comment on October 1, 2025. A public comment period was held between October 1, 2025, through October 31, 2025, during which the public was permitted to submit suggested changes or additions. A public hearing on the proposed changes was held on October 22, 2025.

Director Heather Jordan has taken all comments into consideration, and the following discussion summarizes the public comments received. However, only those comments which requested amended language or other changes are discussed below. The Director omits public comments submitted in support of the proposed changes as discussion of same is unnecessary. All public comments are public records of the Workers' Compensation Administration ("WCA").

Public comments are individually enumerated with the WCA's response to the public comment immediately following. The public comments are organized to track the sequential order of the publicly posted draft of the HCP fee schedule as much as possible:

1. **Anesthesia**: A public comment recommended removal of this sentence from the "Anesthesia" section of the proposed billing instructions: "Anesthesia services provided during a hospital inpatient surgery or procedure shall be reimbursed by applying the appropriate hospital ratio (see page 17, 18. and 19)." The commentator noted that inpatient anesthesia services billed by hospital are already specifically addressed at the end of the anesthesia section, namely: "Anesthesia services billed on form UB-04 CMS-1450 shall be reimbursed by applying the appropriate hospital ratio." The commentator added that the reference to forms UB-04 and CMS-1450 in the last quotation above helps ensure that the hospital ratio applies to anesthesia services billed by the hospital using these billing forms.

WCA RESPONSE: Upon review, the WCA acknowledges that the concluding sentence of the anesthesia section – "Anesthesia service billed on form UB-04 CMS-1450 shall be

reimbursed by applying the appropriate hospital ratio" — does provide the requisite clarification regarding the reimbursement methodology for inpatient anesthesia services billed by hospitals. Accordingly, to avoid redundancy and ensure clarity, we will revise the section to remove the earlier sentence quoted above.

2. **Depositions**: A public comment was received regarding the new inclusion of language in the proposed changes regarding how a health care provider (HCP") should bill for deposition time. The commentator suggested the required use of additional billing modifiers to permit distinct billing by an HCP provider for deposition preparation time (-DP), actual deposition time (-DT), and for cancellation (-DC) as each of these situations have differing rates. Further, the commentator suggested that the HCP be required to bill in "units" to demonstrate the number of 15-minute increments incurred by the provider (for deposition preparation and deposition time, 15 minutes = one unit). A deposition cancellation would be billed at the flat $800 rate.

Another commentator suggested that only the WCA rules should address permitted deposition charges with the annual fee schedule not addressing the same subject as this could lead to confusion for WCA stakeholders.

WCA RESPONSE: The WCA's inclusion of language in the proposed changes on how depositions are to be billed stemmed from the perceived need to include a billing code (99075) when an HCP bills for deposition-related charges. In addition, the WCA's amended rule raising the permitted hourly rate for deposition-related charges represented a material rule change which could surprise WCA stakeholders given that the hourly rate had not been changed for many years. (The amended rule became effective November 7, 2025.) Thus, the WCA thought it appropriate to include in the proposed changes language borrowed from the amended rule to aid in implementation.

The WCA considers the public comments well taken. However, no changes will be made at this time to allow the WCA and all stakeholders more time to evaluate the amended rule and the deposition language in the fee schedule during the 2026 calendar year. As stakeholders become more familiar with the use of a deposition code and the new hourly deposition rate, the WCA will be better positioned to assess whether further clarification or adjustment is needed in a future rulemaking cycle.

3. **Durable Medical Equipment ("DME")**: A commentator suggested that the last sentence of this section - "DME provided during a hospital stay shall be reimbursed by applying the appropriate hospital ratio" - be replaced with the following: "DME provided during a hospital inpatient stay billed on a UB-04 CMS-1450 shall be reimbursed by applying the appropriate hospital ratio."

The commentator explained that this clarification will help ensure that the hospital ratio applies to DME provided on an inpatient basis. Further, the change will align with the existing language for other, inpatient care services, *e.g.*, "Anesthesia services billed on form UB-04 CMS-1450 are reimbursed by applying the appropriate hospital ratio"

WCA RESPONSE: The WCA agrees with the recommendation and will revise the final sentence of the DME section to clarify the use of hospital ratios for the provision of DME during an inpatient stay.

4. **Explanation of Benefits ("EOB")**: A comment suggested that the WCA move completely away from WCA-specific EOB codes altogether and use only CARC and RARC code equivalents to standardize medical billing in workers' compensation cases as much as possible.

WCA RESPONSE: The WCAs adoption and acceptance of national standards CARC and RARC codes in the 2026 fee schedule represents the agency's effort to standardize billing in New Mexico workers' compensation cases measured against national trends. This is an ongoing process, and the WCA believed it premature to remove all traditional WCA-specific codes. The WCA remains committed to standardization and streamlining of permitted billing processes for its stakeholders to reduce the administrative burden and costs. The WCA has initiated outreach to the Industrial Accident Boards and Commissions (IAIABC) to identify potential crosswalks between our WCA-specific EOB codes and the national CARC and RARC codes. Future fee schedules may see a reduction and potential elimination of WCA-specific codes.

5. **Miscellaneous Fees – NMGRT**: Public comment was received regarding the New Mexico Gross Receipts Tax (NMGRT) section. First, the commentator recommended a change to this new language: "All NMGRT must be paid. The NM Workers' Compensation Administration does not have jurisdiction to release a payor from reimbursing NM Gross Receipts Tax." The commentator believed clarification was needed to the effect that NMGRT must be paid on the reimbursed amount to account for applicable discounts versus the full price billed. Second, the commentator suggested the WCA permit a provider who has forgotten to submit a NMGRT bill with its initial billing to merely submit a "new" bill titled "tax only" versus the proposed language which required a forgotten NMGRT billing to be presented as a "reconsideration" or "resubmission" claim. Allowing a "new, tax only" bill would prevent potential conflict with existing WCA rule deadlines and other procedures which govern the "reconsideration" process, such as the deadlines applicable to billing reconsiderations.

WCA RESPONSE: The WCA agrees with the public comments received regarding the NMGRT section. Accordingly, the 2026 Fee Schedule will adopt the recommended language changes. Additionally, the WCA will monitor the NMGRT language changes throughout the 2026 calendar year to measure its impact on stakeholders.

6. **Telehealth Services**: Public comments were received regarding the proposed changes to the billing requirements for telehealth services, which proposed changes included the addition of new definitions to the fee schedule but also substantive changes to how telehealth services are billed. The proposed changes were suggested to comport the WCA fee schedule with changes being made at the national level regarding telehealth services.

A public commentator took issue with the WCA permitting providers to bill the same amount for telehealth services as in-person services. The commentator argued it costs a provider less to provide telehealth services and, accordingly, billing should likewise be less.

Another public comment suggested that providers include in their telehealth service billings a reference to the "place of service" such as the patient's home ("place of service 10") or if the service was provided outside of the patient's home ("place of service 02"). Associated definitions would be added to the fee schedule to help explain the use of these modifiers.

WCA RESPONSE: Regarding telehealth services being billed the same as in-person services, the WCA considered the potential for telehealth services to be billed at a rate less than in-person services for the reasons outlined in the public comment. However, due to the recognized shortage of doctors to treat injured workers in New Mexico, particularly in rural areas, the WCA believed it necessary to not disincentivize providers from treating injured workers which could happen if telehealth services were billed at a lesser rate than in-person services. The WCA considers this an access to care issue, which is important to all WCA stakeholders. The WCA also did not want to have workers' compensation telehealth services reimbursed at a rate less than similar services provided under group health insurance policies; such disparity would also disincentivize medical providers treating injured workers.

At this time, the WCA has elected to not add into the telehealth services billing requirement a "place of service" modifier. It is believed that the proposed changes which include the use of modifiers 93 and 95 adequately address place of service considerations. The WCA will monitor the telehealth language changes during the 2026 calendar year to assess whether additional modifiers would bring further clarity regarding telehealth billing.

7. **Time Spent with Patient**. Public comment was received regarding proposed changes to the section entitled: "Time Spent with Patient." First, the commentator suggested changing the section's title to "Time-Based CPT Coding Documentation." Second, changes were suggested regarding this language of the proposed changes – "If a provider is billing a CPT code based on the amount of time spent with the patient instead of medical decision making, the time must be documented in the medical notes." The commentator relayed that the proposed language was vague and failed to adequately track how this subject is currently addressed by AMA CPT guidelines. This substitute language was suggested:

> "When billing a CPT code based on time, the total time spent must be documented in the medical record, in accordance with AMA CPT guidelines. Documentation should clearly reflect the total time spent on each activity. Total time is defined as the total time on the date of the encounter spent by the physician or other qualified health care professional (QHP) personally in the care of the patient for face-to-face and non-face-to-face activities such as counseling, care coordination, record review, or other services directly related to the patient. This applies to E/M visits, critical care, therapy services, prolonged services, and hospital or observation care."

WCA RESPONSE: The WCA agrees with the public comments received regarding the "Time Spent with Patient" section. The title change and proposed language quoted above will reduce ambiguity and help align the WCA with AMA CPT guidelines. The WCA will adopt the

recommendations. The WCA will monitor these changes during the 2026 calendar year to measure its impact on stakeholders.

8. **Work Related or Medical Disability Examination Services**. A public comment was received regarding work-related disability examination services. Like past years, it was again suggested that the WCA move from "by report" for work related or medical disability examination services to a flat rate for services such as impairment ratings and independent medical examinations.

WCA RESPONSE: The WCA Economic Research Bureau continues to research this issue in terms of determining an appropriate methodology and price point for these services.

9. **CPT Code Specific Comment**: A public comment was received regarding specific CPT codes and the rates assigned to those codes. Specifically, a commentator believed these CPT codes - 80074, 84450, 86706, 87240, and 87389 - were priced too low. These codes pertain to blood testing following an exposure by a first responder, medical workers or teachers to a transmitted disease such as hepatitis or HIV. The comment suggested that the rate assigned for these services is too low relative to the costs incurred in performing these tests.

WCA RESPONSE: Any changes to the listed codes require the Economic Bureau of the WCA to conduct research into the fee schedule methodology for pathology and laboratory services. The WCA hopes to undertake that research to evaluate the propriety of the comment, including whether the fee schedule is underpricing those specific codes, thereby resulting in revenue loss for providers who bill those specific CPT codes.

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