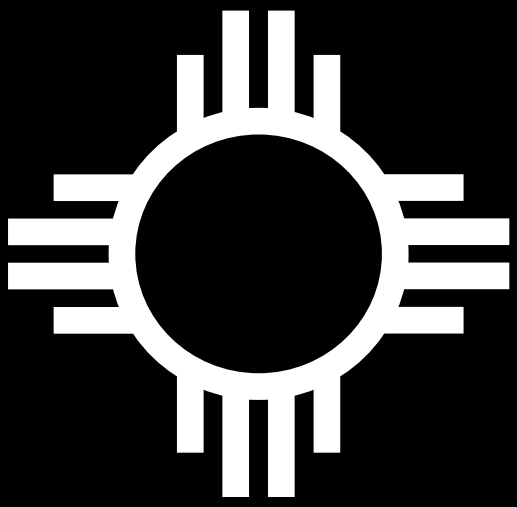
NEW MEXICO REGISTER



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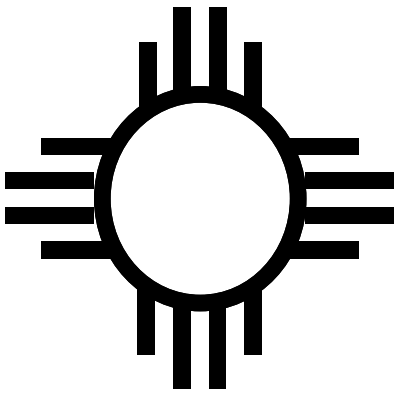

The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2006

New Mexico Register

Volume XVII, Number 4
February 28, 2006

Table of Contents

Notices of Rulemaking and Proposed Rules

Adopted Rules

Effective Date and Validity of Rule Filings

Rules published in this issue of the New Mexico Register are effective on the publication date of this issue unless otherwise specified. "No rule shall be valid or enforceable until it is filed with the records center and published in the New Mexico register as provided by the State Rules Act. Unless a later date is otherwise provided by law, the effective date of a rule shall be the date of publication in the New Mexico register." Section 14-4-5 NMSA 1978.

A=*Amended*, E=*Emergency*, N=*New*, R=*Repealed*, Rn=*Renumbered*

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Notices of Rulemaking and Proposed Rules

NEW MEXICO BOARD OF ACUPUNCTURE AND ORIENTAL MEDICINE

PUBLIC RULE HEARING & REGULAR MEETING NOTICE

The New Mexico Board of Acupuncture and Oriental Medicine will convene a public rule hearing on Wednesday, April 5, 2006. The hearing will begin at 9 a.m. The meeting will be located at the State Capitol Building, 3rd Floor, Room 307, 415 Old Santa Fe Trail in Santa Fe, New Mexico. The purpose of the rule hearing is to hear public testimony and comments regarding the proposed revisions to the rules and regulations: PART 1 General Provisions, PART 2 Scope of Practice, PART 8 License Renewal, PART 9 Continuing Education, PART 10 Fees, PART 16 Auricular Detoxification.

A board meeting will follow the hearing. The board may go into executive session to discuss pending litigation, personnel or licensee matters. A final agenda for the board meeting will be available at the board office on April 4, 2006. Persons desiring to present their views on the proposed amendments may appear in person at said time and place or may submit written comments no later than 5:00 p.m. on March 22, 2006, to the board office, P.O. Box 25101, Santa Fe, NM, 87504. Copies of the proposed rule changes are available on through the board office and on the Board's website which is www.rld.state.nm.us/b&c/acupuncture (click on the "News" link).

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing or meeting, please contact the board administrator at 476-4627 at least one week prior to the meeting or as soon as possible. Public documents, including the agenda and minutes, can be provided in various accessible formats. Please contact the board administrator if a summary or other type of accessible format is needed.

NEW MEXICO DEPARTMENT OF AGRICULTURE

Notice of Hearing

New Mexico Department of Agriculture will hold two public hearings under the New Mexico Pesticide Control Act, 76-4-1 through 39, NMSA 1978. NMDA is proposing changes to the current 2, 4-D permit program in Curry and Roosevelt Counties. The changes include allowing commercial applicators to apply for the permit on behalf of landowners, extending the permit time from 7 days to 30 to allow applicators to provide for weather delays and apply during the best conditions, coordinated dates of application restrictions, and provided an exemption from permit requirements for spot applications. Copies of the proposed rule can be obtained at the address below or viewed on the Bureau's webpage at: http://www.nmda.nmsu.edu/DIVISIONS/AES/pest.html and clicking on New Information.

The first hearing will be held in Clovis at the Curry County Fairgrounds Cooperative Extension Building, located at 600 S. Norris Clovis, NM, beginning at 10:00 a.m. on Tuesday April 11, 2006.

A second hearing will be held in Portales at the Memorial Building located at 201 E. 7th (Corner of 7th and Abilene) Portales, NM, beginning at 10:00 a.m. on Wednesday April 12, 2006.

Written statements in support or opposition, signed by the submitting person, will be accepted if received prior to 5:00 p.m., April 12, 2006. Written statements, inquiries, or requests for copies of the rule should be directed to Bonnie Rabe, New Mexico Department of Agriculture, Bureau of Pesticide Management, PO Box 30005, MSC 3AQ, Las Cruces, NM 88003 or at (505) 646-2133.

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD

The New Mexico Environmental Improvement Board (EIB) postponed the public hearing originally set for January 3-6, 2006 on the repeal and replacement of 20.9.1 NMAC, the Solid Waste Management Regulations. The hearing will be held May 2-5, 2006. The EIB also appointed a new Hearing Officer in the matter. Her contact information is below:

Felicia Orth, Hearing Officer
New Mexico Environment Department
1190 St. Francis Drive, P.O. Box 26110
Santa Fe, New Mexico 87502-6110
Tele: (505) 827-0339
Fax: (505) 827-2836
E-mail: felicia.orth@state.nm.us

The Hearing Officer will finalize an amended Scheduling Order and Hearing Guidelines following consultation with the parties. This document will contain the new location and times for the hearing, and new pre-hearing deadlines for submittals such as notices of intent to present technical testimony and exhibits. The document will be posted on the New Mexico Environment Department (NMED) webpage; it can also be requested and obtained by mail, e-mail or facsimile transmission.

The proposed new rule may be reviewed during regular business hours by contacting the EIB Administrator, Joyce Medina. Her contact information is below:

Joyce Medina, Administrator of Boards and Commissions
New Mexico Environment Department
1190 St. Francis Drive, P.O. Box 26110
Santa Fe, New Mexico 87502-6110
Tele: (505) 827-2425
Fax: (505) 827-2836
E-mail: joyce.medina@state.nm.us

The proposed new rule may also be seen at the NMED webpage at http://www.nmenv.state.nm.us/swb/draftregs.htm.

OIL CONSERVATION COMMISSION

NOTICE OF RULEMAKING

STATE OF NEW MEXICO
ENERGY, MINERALS AND NATURAL
RESOURCES DEPARTMENT
OIL CONSERVATION COMMISSION
SANTA FE, NEW MEXICO

The State of New Mexico, through its Oil Conservation Commission, hereby gives notice that the Commission will conduct a public hearing at 9:00 A.M. on **Thursday, March 23, 2006,** in Porter Hall at 1220 South St. Francis Drive, Santa Fe, New Mexico, concerning the adoption of amendments to 19.15.1, 19.15.2 and 19.15.9 NMAC. The proposed amendments will amend Section 7 of 19.15.1 NMAC to change the definition of "oil field wastes," and the definition of "watercourse," and to adopt of new definitions of "biopile," "soil" and "surface waste management facility." The proposed amendments will also amend 19.15.9 NMAC by removing Sections 709 (concerning transportation of produced water), 710 (concerning disposition of produced water) and 711(concerning surface waste management facilities) to 19.15.2

NMAC, where these sections will become new Sections 51 (Transportation of Produced Water, Drilling Fluids and Other Liquid Oil Field Waste), 52 (Disposition of Produced Water and Other Oil Field Wastes) and 53 (Surface Waste Management Facilities) of 19.15.2 NMAC. These sections [19.15.2.51, 19.15.2.52 and 19.15.2.53 NMAC] will be substantially re-written to provide revised permitting requirements for transporters of produced water and oil field wastes, to revise rules for disposition of produced water and other oil field wastes, and to revise permitting requirements and procedures and sitting, design, construction and operational requirements for surface waste management facilities. Copies of the text of the proposed amendments are available from Division Administrator Florene Davidson at (505)-476-3458 or from the Division's web site at http://www.emnrd.state.nm.us/ocd/whatsnew.htm. Proposed alternative rule amendments must be received by the division no later than 5:00 P.M. on Thursday, March 9, 2006. Written comments on the proposed amendments must be received no later than 5:00 P.M. on Thursday, March 16, 2006. Proposed alternative rule amendments and written comments may be hand-delivered or mailed to Ms. Davidson at 1220 South St. Francis Drive, Santa Fe, New Mexico 87505, or may be faxed to Ms. Davidson at 476-3462. If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing, please contact Ms. Davidson at (505)-476-3458 or through the New Mexico Relay Network (1-800-659-1779) as soon as possible.

Given under the Seal of the State of New Mexico Oil Conservation Commission at Santa Fe, New Mexico on this 13 day of February, 2006.

STATE OF NEW MEXICO
OIL CONSERVATION DIVISION

Mark E. Fesmire, P.E.
Director, Oil Conservation Division

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

NEW MEXICO TAXATION AND REVENUE DEPARTMENT

NOTICE OF HEARING AND PROPOSED RULES

The New Mexico Taxation and Revenue Department proposes to adopt the following regulations:

Tax Administration Act
3.1.1.7 NMAC Section 7-1-71.1 NMSA 1978
("Sign" Defined)
3.1.12.12 NMAC Section 7-1-10 NMSA 1978
(Liquor Wholesale Reporting Requirements)

Gross Receipts and Compensating Tax Act
3.2.241.9 NMAC Section 7-9-93 NMSA 1978
(Receipts From Third Party Claims Administrators)
3.2.241.10 NMAC Section 7-9-93 NMSA 1978
(Receipts From Insurance Companies Pursuant to Contracts With Independent Practice Organizations)
3.2.241.11 NMAC Section 7-9-93 NMSA 1978
(Receipts for Administrative Services Not Deductible)
3.2.241.12 NMAC Section 7-9-93 NMSA 1978
(Receipts Not Deductible Under Section 7-9-93 NMSA 1978)
3.2.241.13 NMAC Section 7-9-93 NMSA 1978
(Receipts of Corporate Practice)
3.2.241.14 NMAC Section 7-9-93 NMSA 1978
(Valid Certificate of Compliance Required)
3.2.241.15 NMAC Section 7-9-93 NMSA 1978
(Self-Insurance May Be "Managed Health Care Providers")
3.2.241.16 NMAC Section 7-9-93 NMSA 1978
(Payments From Workers Compensation)
3.2.241.17 NMAC Section 7-9-93 NMSA 1978
(Receipts of Health Care Facilities Not Deductible)
3.2.241.18 NMAC Section 7-9-93 NMSA 1978
(Receipts From "Medigap" Insurance Policies Not Deductible)

Personal Income Tax Act
3.3.1.9 NMAC Section 7-2-2 NMSA 1978
(Residency)

The proposals were placed on file in the Office of the Secretary on February 13, 2006. Pursuant to Section 9-11-6.2 NMSA 1978 of the Taxation and Revenue Department Act, the final of the proposals, if filed, will be filed as required by law on or about April 14, 2006.

A public hearing will be held on the proposals on Thursday, March 30, 2006, at 9:30 a.m. in the Secretary's Conference Room No. 3002/3137 of the Taxation and Revenue Department, Joseph M. Montoya Building, 1100 St. Francis Drive, Santa Fe, New Mexico. Auxiliary aids and accessible copies of the proposals are available upon request; contact (505) 827-0928. Comments on the proposals are invited. Comments may be made in person at the hearing or in writing. Written comments on the proposals should be submitted to the Taxation and Revenue Department, Director of Tax Policy, Post Office Box 630, Santa Fe, New Mexico 87504-0630 on or before March 30, 2006.

3.1.1.7 **D E F I N I T I O N S: "SIGN" DEFINED:** As used in Section 7-1-71.1 NMSA 1978 and Section 3.1.1.18 NMAC the term "sign" means to affix a name or cause it to be attached using one of the following methods:

A. rubber stamp;

B. mechanical device (such as a mechanical pen);

C. computer software program; or

D. any other method of signature acceptable under the Internal Revenue Code.

[10/31/96; 3.1.1.7 NMAC - Rn, 3 NMAC 1.1.7, 12/29/00; A, XXX]

3.1.12.12 **LIQUOR WHOLESALE REPORTING REQUIREMENTS:** Any person doing business in the state of New Mexico as a liquor wholesaler shall file monthly reports, providing sales information necessary to the administration of the Gross Receipts and Compensating Tax Act, in form and content as prescribed by the department. The monthly report is due by the 25th day of the month following the close of the calendar month in which the alcoholic beverages are sold.

[3.1.12.12 NMAC - N, XXX]

3.2.241.9 **RECEIPTS FROM THIRD PARTY CLAIMS ADMINISTRATORS:** Payments by a third party claims administrator to a health care practitioner for health care services rendered by the practitioner within the scope of his or her practice and pursuant to a contract with

a managed care company or a health insurer that are otherwise deductible under Section 7-9-93 NMSA 1978 may be deducted from gross receipts. A third party claims administrator is an entity that processes health care claims and performs related business functions for a health plan.
[3.2.241.9 NMAC - N, 4/29/05; 3.2.241.9 NMAC - N, XXX]

3.2.241.10 **RECEIPTS FROM INSURANCE COMPANIES PURSUANT TO CONTRACTS WITH INDEPENDENT PRACTICE ORGANIZATIONS:**

A. For purposes of Section 7-9-93 NMSA 1978, an "independent practice association" is defined as a entity which acts as an administrative intermediary between medical practitioners and insurance companies. The independent practice association contracts with both insurance companies and practitioners. Each practitioner contracted with the panel is qualified to receive reimbursement from each insurer contracted with the independent practice association subject to limitations and a fee schedule established by the independent practice association and agreed to by both parties through their individual contracts with the independent practice association. Thus, a single contract between a practitioner and a independent practice association eliminates the need for the individual contracts between the practitioner and the independent practice association's insurers. Payments by insurers to practitioners pursuant to a both parties' contracts with an independent practice association and that are otherwise deductible under Section 7-9-93 NMSA 1978 are deductible.

B. Example: A doctor contracts with an independent practice association. The doctor bills and receives payment from an insurance company that is also contracted to the independent practice association. The insurance company is registered in New Mexico. Even though the doctor does not have a direct contract with the insurance company, he or she may deduct payments he or she receives for services that are otherwise deductible under Section 7-9-93 NMSA 1978 because he or she has contracted with the independent practice association.
[3.2.241.10 NMAC - N, 4/29/05; 3.2.241.10 NMAC - N, XXX]

[~~3.2.241.16~~] 3.2.241.11 **RECEIPTS FOR ADMINISTRATIVE SERVICES NOT DEDUCTIBLE:** Receipts of a third party for administering a health insurance or medical plan are not deductible under Section 7-9-93 NMSA 1978.
[3.2.241.11 NMAC - N, 4/29/05; 3.2.241.11 NMAC - Rn, 3.2.241.16 NMAC, XXX]

[~~3.2.241.9~~] 3.2.241.12 **RECEIPTS NOT DEDUCTIBLE UNDER SECTION 7-9-93 NMSA 1978:** Receipts of a health care practitioner other than from payments by a managed health care provider or health care insurer for commercial contract services or medicare part C services provided by the health care practitioner are not deductible under Section 7-9-93 NMSA 1978. Receipts of health care practitioners not deductible under Section 7-9-93 NMSA 1978 include:

A. receipts from any payment, such as a co-payment, that is the responsibility of the patient under the managed health care plan or health insurance;

B. receipts on a fee-for-service basis; "fee-for-service" means a traditional method of paying for health care services under which health care practitioners are paid for each service rendered, as opposed to paying in accordance with a schedule of fees in a contract the health care provider has entered into with a third party; and

[~~C. receipts from providing services to medicaid patients; and~~]

[~~D.~~]C. receipts from selling tangible personal property such as nonprescription medicine that is not incidental to the provision of a deductible service.
[3.2.241.12 NMAC - N, 4/29/05; 3.2.241.12 NMAC - Rn & A, 3.2.241.9 NMAC, XXX]

[~~3.2.241.10~~] 3.2.241.13 **RECEIPTS OF CORPORATE PRACTICE:** [~~A professional corporation or unincorporated business association, may deduct under Section 7-9-93 NMSA 1978 its receipts from managed health care providers or health care insurers for commercial contract services or medicare part C services provided on its behalf by health care practitioners who own or are employed by the corporation or unincorporated business association if:~~

~~A. the professional corporation or unincorporated business association is owned exclusively by licensed health care practitioners described in Section 7-9-93 NMSA 1978; or at least eighty percent of the ownership interest of a corporation other than a professional corporation or an unincorporated business association is owned by licensed health care professional described in Section 7-9-93 NMSA 1978; and~~

~~B. the corporation or unincorporated business association is not an organization described by Subsection A of Section 7-9-29 NMSA 1978 or a hospital, hospice, nursing home, outpatient facility or intermediate care facility licensed under the Public Health Act.~~]

A corporation, unincorporated business association, or other legal entity may deduct under Section 7-9-93 NMSA 1978 its receipts from managed health care providers or health care insurers for commercial contract services or medicare part C services provided on its behalf by health care practitioners who own or are employed by a corporation, unincorporated business association or other legal entity that is not:

A. an organization described by Subsection A of Section 7-9-29 NMSA 1978; or

B. an HMO, hospital, hospice, nursing home, an entity that is solely an outpatient facility or intermediate care facility licensed under the Public Health Act.
[3.2.241.13 NMAC - N, 4/29/05; 3.2.241.13 NMAC - Rn & A, 3.2.241.10 NMAC, XXX]

[~~3.2.241.11~~] 3.2.241.14 **VALID CERTIFICATE OF COMPLIANCE REQUIRED:** A person is not a "health care insurer" as defined by Section 7-9-93 NMSA 1978 if the person does not have a valid certificate of compliance issued by the public regulation commission under the New Mexico insurance code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan. Receipts of health care practitioners from persons without such a valid certificate of compliance are not deductible under Section 7-9-93 NMSA 1978.
[3.2.241.14 NMAC - N, 4/29/05; 3.2.241.14 NMAC - Rn, 3.2.241.11 NMAC, XXX]

[~~3.2.241.12~~] 3.2.241.15 **SELF-INSURERS MAY BE "MANAGED HEALTH CARE PROVIDERS":** If a person provides for the delivery of comprehensive basic health care services and medically necessary services to the person's employees enrolled in a self-insurance plan through contracting with selected or participating health care practitioners, that person is a "managed health care provider". Example: New Mexico state government's self-insured plan under the Group Benefits Act.
[3.2.241.15 NMAC - N, 4/29/05; 3.2.241.15 NMAC - Rn, 3.2.241.12 NMAC, XXX]

[~~3.2.241.13~~] 3.2.241.16 **PAYMENTS FROM WORKERS COMPENSATION:** Receipts of a health care practitioner from the state of New Mexico pursuant to the Workers Compensation Act are not receipts from a managed health care provider or health care insurer and are not deductible under Section 7-9-93 NMSA 1978.
[3.2.241.16 NMAC - N, 4/29/05; 3.2.241.16 NMAC - Rn, 3.2.241.13 NMAC, XXX]

[~~3.2.241.14~~] 3.2.241.17 **RECEIPTS OF HEALTH CARE FACILITIES NOT DEDUCTIBLE:** An organization, whether

or not owned exclusively by health care practitioners, licensed as a hospital, hospice, nursing home, an entity that is solely an outpatient facility or intermediate care facility under the Public Health Act is not a "health care practitioner" as defined by Section 7-9-93 NMSA 1978. Receipts of such an organization are not deductible under Section 7-9-93 NMSA 1978.
[3.2.241.17 NMAC – Rn & A, 3.2.241.14 NMAC, XXX]

[~~3.2.241.15~~] 3.2.241.18 **RECEIPTS FROM "MEDIGAP" INSURANCE POLICIES NOT DEDUCTIBLE:** [~~Payments from an insurer in accordance with a Medigap policy supplementing Medicare coverage are not deductible under Section 7-9-93 NMSA 1978. Medigap policies are not paying for "commercial contract services" as defined by Section 7-9-93 NMSA 1978.~~] Payments from an insurer in accordance with a medigap policy are not deductible under Section 7-9-93 NMSA 1978. For purposes of the deduction under Section 7-9-93 NMSA 1978, a medigap policy meets the statutory definition of a "medicare supplemental policy" contained in Section 1882(g)(1) of title XVIII of the Social Security Act. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to medicare benefits and is specifically designed to supplement medicare benefits. It does not include limited benefit coverage available to medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members. Medigap policies are not paying for "commercial contract services" as defined by Section 7-9-93 NMSA 1978.
[3.2.241.18 NMAC - Rn & A, 3.2.241.15 NMAC, XXX]

3.3.1.9 **RESIDENCY**

A. **Full-year residents.** For purposes of the Income Tax Act, the following are full-year residents of this state:

(1) an individual domiciled in this state during all of the taxable year, or

(2) an individual other than an individual described in Subsection D of this Section who is physically present in this state for a total of one hundred eighty-five (185) days or more in the aggregate during the taxable year, regardless of domicile.

B. **Part-year residents.**

(1) An individual who is domiciled in New Mexico for part but not all of the taxable year, and who is physically present in New Mexico for fewer than 185 days, is a part-year resident.

(a) During the first taxable year in which an individual is domiciled in New Mexico, if the individual is physically present in New Mexico for less than a total of 185 days, the individual will be treated as a non-resident of New Mexico for income tax purposes for the period prior to establishing domicile in New Mexico.

(b) An individual domiciled in New Mexico who is physically present in New Mexico for fewer than 185 days and changes his [~~place of abode~~] domicile to a place outside this state with the bona fide intention of continuing to live permanently outside New Mexico, is not a resident for Income Tax Act purposes for periods after that change of [~~abode~~] domicile.

(2) An individual who moves into this state with the intent to make New Mexico his permanent domicile is a first-year resident. A first-year resident should report any income earned prior to moving into New Mexico as nonresident income even if he is physically present in New Mexico for 185 days or more.

C. **"Domicile" defined:**

(1) A domicile is [~~a place of a true, fixed home, a permanent establishment where one intends to return after an absence and where a person~~] the place where an individual has a true, fixed home, is a permanent establishment to which the individual intends to return after an absence, and is where the individual has voluntarily fixed habitation of self and family with the intention of making a permanent home. Every individual has a domicile somewhere, and each individual has only one domicile at a time.

[~~(2) The following individuals are presumed to be domiciled in New Mexico:~~

~~(a) an individual who is registered to vote in the state during a taxable year who has not subsequently registered to vote elsewhere outside this state on or before the last day of the taxable year;~~

~~(b) an individual who holds a valid driver's license issued by the taxation and revenue department pursuant to the Motor Vehicle Code and who has not been subsequently licensed by another state on or before the last day of the taxable year; or~~

~~(c) an individual who has claimed to be a New Mexico resident for any other official purpose, such as eligibility for resident tuition at state schools, colleges or universities, or for hunting or fishing licenses.~~

~~(3) An individual presumed to be domiciled in New Mexico may rebut the presumption by establishing by a preponderance of evidence the state in which the individual is domiciled.~~]

(2) Once established, domicile does not change until the individual moves to a new location with the bona fide intention of making that location his or her permanent home.

(3) No change in domicile results when an individual leaves the state if the individual's intent is to stay away only for a limited time, no matter how long, including:

(a) for a period of rest or vacation;

(b) to complete a particular transaction, perform a contract or fulfill an engagement or obligation, but intends to return to New Mexico whether or not the transaction, contract, engagement or obligation is completed, or

(c) to accomplish a particular purpose, but does not intend to remain in the new location once the purpose is accomplished.

(4) To determine domicile, the department shall give due weight to an individual's declaration of intent. However, those declarations shall not be conclusive where they are contradicted by facts, circumstances and the individual's conduct. In particular, the department will consider the following factors in determining whether an individual is domiciled in New Mexico (the list is not intended to be exclusive and is in no particular order):

(a) homes or places of abode owned or rented (for the individual's use) by the individual, their location, size and value; and how they are used by the individual;

(b) where the individual spends time during the tax year and how that time is spent; e.g., whether the individual is retired or is actively involved in a business, and whether the individual travels and the reasons for traveling, and where the individual spends time when not required to be at a location for employment or business reasons, and the overall pattern of residence of the individual;

(c) employment, including how the individual earns a living, the location of the individual's place of employment, whether the individual owns a business, extent of involvement in business or profession and location of the business or professional office, and the proportion of in-state to out-of-state business activities;

(d) home or place of abode of the individual's spouse, children and dependent parents, and where minor children attend school;

(e) location of domicile in prior years;

(f) ownership of real property other than residences;

(g) location of transactions with financial institutions, including the individual's most active checking account and rental of safety deposit boxes;

(h) place of community affiliations, such as club and professional and social organization memberships;

(i) home address used for filing federal income tax returns;

(j) place where individual is registered to vote;

(k) state of driver's license or professional licenses;

(l) resident or nonresident status for purposes of tuition at state schools, colleges and universities, fishing and hunting licenses, and other official purposes; and

(m) where items or possessions that the individual considers "near and dear" to his or her heart are located, e.g., items of significant sentimental or economic value (such as art), family heirlooms, collections or valuables, or pets.

(5) The department shall evaluate questions regarding domicile on a case-by-case basis. No one of the factors considered by the department shall be conclusive with respect to an individual's domicile. Factors such as the state of driver's license, place of voter registration and home address may be given less weight, depending on the circumstances, because they are relatively easy to change for tax purposes.

D. **"Domicile" and residency for armed forces personnel.**

(1) A resident of this state who is a member of the United States armed forces does not lose residence or domicile in this state, or gain residency or domicile in another state, solely because the service member left this state in compliance with military orders.

(2) A resident of another state who is a member of the United States armed forces does not acquire residence or domicile in this state solely because the service member is in this state in compliance with military orders.

(3) A resident of another state who is a member of the United States armed forces does not become a resident of this state solely because the service person is in this state for one hundred and eighty-five (185) or more days in a taxable year.

(4) Compensation for service in the armed forces is subject to personal income tax only in the state of the service member's domicile. "Compensation for military service" does not include compensation for off-duty employment, or military retirement income.

(5) For purposes of this section, "armed forces" means all members of the army of the United States, the United States navy, the marine corps, the air force, the coast guard, all officers of the public health service detailed by proper authority for duty either with the army or the navy, reservists placed on active duty, and members of the national guard called to active federal duty.

E. **Examples:**

(1) A, a life-long resident of Texas, accepts a job in New Mexico. On December 5, 2003, A moves to New Mexico with the intention of making New Mexico her permanent home. A has established domicile in New Mexico during the 2003 tax year. Because she was physically present in New Mexico for fewer than 185 days during that year, she should file as a part-year resident, and she will be treated as a resident for personal income tax purpose only for that period after she establishes a New Mexico domicile.

(2) B, a resident of Arizona, makes several weekend visits to New Mexico in the early months of 2004. On July 1, 2004, he moves to New Mexico with the intention of making it his permanent home. Family matters call him back to Arizona on August 1, 2004, and he soon determines that he must remain in Arizona. B was domiciled in New Mexico during the thirty days he spent in this state with the intention of making it his permanent home. Because B was physically present in this state for fewer than 185 days in 2004, B should file as a part-year resident for that tax year. For personal income tax purposes he will be treated as a resident of New Mexico only from July 1 to August 1, 2004.

(3) C was born and raised in New Mexico. She leaves New Mexico in December 2003 to pursue a two-year master's degree program in Spain. She intends to return to New Mexico when she completes her studies. During her absence she keeps her New Mexico driver's license and voter registration. Because New Mexico remains her domicile, C should file returns for tax years 2003, 2004 and 2005 as a full-year New Mexico resident.

(4) D, a resident of California, comes to New Mexico on three separate occasions in 2004 to work on a movie. D does not intend to remain in New Mexico, and when the movie is completed, D returns to her home in California. D is physically present in New Mexico for 200 days in 2004. Because D was physically present in New Mexico for at least 185 days, D must file as a full-year resident of New Mexico for tax year 2004.

(5) E, a resident of New Mexico, joined the army. Since joining the military, E has been stationed in various places around the world. Although E has not been back to New Mexico in the ten years since he joined the army, he continues to vote in New Mexico and holds a current New Mexico driver's license. E must file as a full-year resident of New Mexico.

(6) Same facts as Example 5, except that in August 2003, while stationed in Georgia, E retires from the military. Instead of returning to New Mexico, E moves to Florida where he intends to spend his retirement. For tax year 2003, E must file as a part-year resident, because he was not physically present in the state for 185 days or more. E is a resident of New Mexico until August 2003, when he moves to Florida with the intent of making that his permanent home.

(7) F, a resident of Texas, is an air force officer. In March 2002 he moves to New Mexico with his spouse to begin a two-year assignment at Kirtland Air Force Base. F is registered to vote in Texas and holds a Texas driver's license. F is not a resident of New Mexico in 2002. F's spouse is a full-year resident of New Mexico in 2002, regardless of domicile, because she is physically present in New Mexico for 185 days or more. During the second year of F's assignment, he registers to vote in New Mexico, obtains a New Mexico driver's license, and enrolls his son in a New Mexico university paying resident tuition. Although F's presence in New Mexico under military orders is not sufficient to establish New Mexico residency or domicile, his conduct in 2003 is sufficient to establish domicile. In 2003 F must file as a part-year resident of New Mexico. He will be treated as a non-resident for income tax purposes for that period of 2003 prior to establishing domicile in New Mexico.

(8) G is a Native American who lives and works on his tribe's pueblo in New Mexico. Federal law prohibits the state from taxing income earned by a Native American who lives and works on his tribe's territory. G joins the marines and is stationed outside New Mexico. Because G's domicile remains unchanged during his military service, G's income from military service is treated as income earned on the tribe's territory by a tribal member living on the tribe's territory, and is not taxable by New Mexico.

[10/23/85, 12/29/89, 3/16/92, 6/24/93, 1/15/97; 3.3.1.9 NMAC - Rn & A, 3 NMAC 3.1.9, 12/14/00, A, 4/29/05; A, XXX]

End of Notices and Proposed Rules Section

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Adopted Rules

NEW MEXICO BOARD OF EXAMINERS FOR ARCHITECTS

This is an amendment to 16.30.3 NMAC, Section 11, effective March 12, 2006.

16.30.3.11 REGISTRATION RENEWAL:

A. Fees: Renewal fees are paid biennially in even-numbered years. New registrations occurring in a non-renewal year shall be prorated on a yearly basis and shall expire on December 31st of that odd-numbered year. The fees for two (2) years are:

(1) in state …….$225.00

(2) out of state …….. $325.00

B. Continuing education: Effective December 31, 2001, all architects will be required to show compliance with these mandatory education requirements as a condition for renewing registration:

(1) Purpose and scope:

(a) These rules provide for a continuing education program to insure that all architects remain informed of these technical subjects necessary to safeguard life, health, property, and promote the public welfare.

(b) Continuing education is focused on registrants becoming more proficient at their architectural practice. Activities not at an architectural registrant level or within an architectural context cannot be claimed for continuing education credit.

(c) Pro bono activities should be seen as the opportunity to "round out" one's continuing education experience; all pro bono activities (serving on committees, providing architectural services and mentoring) as well as tours, business seminars or classes, and architectural history seminars or classes [~~should~~] will be considered general [~~not public protection unless the registrant documents how the registrant (not the community or client) gained specific public protection knowledge~~] subject hours.

(d) These rules apply to all architects registered in New Mexico.

(2) Definitions:

(a) "Eligible contact hour" means fifty (50) minutes actual time engaged in continuing education activities supported by documentation of content and registrant participation.

(b) "Health, safety and welfare in architecture" is anything that relates to the structure or soundness of a building or site or its role in promoting the health, safety or well being of its occupants.

(c) "Public protection hours" means continuing education contact hours in which the subject matter is health, safety and welfare as defined in Subparagraph (b) of Paragraph (2) of Subsection B of 16.30.3.11 NMAC above. Sixteen (16) public protection hours are required for each renewal cycle, however registrants may complete all twenty-four (24) contact hours in public protection subjects.

(d) "General subjects" refers to eight (8) of the total twenty-four (24) contact hours required per renewal cycle which may be in areas other than public protection but which must focus on increasing the registrant's architectural knowledge. All pro bono activities [~~are general subjects unless the registrant documents how the registrant (not the community or client) gained specific health, safety and welfare knowledge~~] must be listed under general subjects.

(e) "Continuing education provider" means any association, organization or business entity which supplies structured, architectural registrant continuing education activities and the corresponding documentation of content and participation. If a continuing education provider includes a testing component to be successfully completed in order to receive a certificate, the registrant must complete all phases of the provider's program. Contact hours shall be credited as indicated by the provider.

(3) Requirements:

(a) To renew registration, in addition to other requirements, an architect must have acquired continuing education for each 24-month period since the architect's last renewal of initial registration, or be exempt from these continuing education requirements as provided below. Failure to comply with these requirements may result in non-renewal of the architect's registration, or other disciplinary action, or both.

(b) Renewal period: For any 24-month biennial renewal period a total of twenty-four (24) contact hours from the activities listed in Paragraph (4) of Subsection B of 16.30.3.11 NMAC below must be reported. At least sixteen (16) contact hours shall be in public protection subjects: safeguarding life, health, property and promoting the public welfare. The remaining eight (8) hours may be acquired in more general subjects. No more than eight (8) hours may be carried over from one renewal cycle to another. Hours that are carried over must be obtained in the renewal cycle immediately preceding the current renewal period. The intent of using carry-over hours is to allow a registrant who has obtained up to thirty-two (32) hours in the previous renewal cycle to be able to carry over up to eight (8) of those hours.

(4) Activities: The following list shall be used by all registrants in determining the types of activities that would fulfill continuing education requirements:

(a) contact hours in attendance at short courses or seminars dealing with architectural subjects and sponsored by academic institutions;

(b) contact hours in attendance at technical presentations on architectural subjects which are held in conjunction with conventions or at seminars related to materials use and functions; such presentations as those sponsored by the American institute of architects, construction specifications institute, construction products manufacturers council or similar organizations devoted to architectural education may qualify;

(c) contact hours in attendance at short courses or seminars related to business practice or new technology and offered by colleges, universities, professional organizations or system suppliers;

(d) contact hours spent in self-study courses such as those sponsored by the national council of architectural registration boards, American institute of architects or similar organizations;

(e) up to three preparation hours may be credited for each class hour spent teaching architectural courses or seminars; college or university faculty may not claim credit for teaching regular curriculum courses;

(f) up to three (3) contact hours spent in architectural research that is published or formally presented to the profession or public;

(g) college or university credit courses dealing with architectural subjects or business practice; each semester hour shall equal fifteen (15) contact hours; a quarter hour shall equal ten (10) contact hours;

(h) the following activities are allowed under general subject hours only and may not be used for public protection hours:

[~~**(h)**~~] (i) contact hours spent in professional service to the public or profession on boards, commissions or committees that draw upon the registrant's professional expertise, such as: serving on planning commissions, building code advisory boards, urban renewal boards, professional boards or committees or code study committees; except as allowable by law, all services must be provided pro bono;

[~~**(i)**~~] (ii) a maximum of eight (8) contact hours biennially for architectural services donated to charitable, religious, educational or other public or private non-profit organization, as defined under Section 501 (c) (3) of the Internal Revenue

Code, organized for the benefit of the general public;

[~~(j)~~] (iii) mentoring: a maximum of eight (8) contact hours biennially may be acquired for serving as a mentor for the intern development program (IDP) or the A.R.E. study sessions; alternatively, a maximum of eight (8) contact hours may be acquired for serving as mentor for student/intern architectural projects that benefit the general public;

[~~(k)~~] (iv) contact hours spent in educational tours of architecturally significant buildings, where the tour is sponsored by a college, university or professional organization and the presentation content is designed for architect participants.

(5) Records and record-keeping:

(a) A registered architect shall complete and submit forms prescribed or accepted by the board certifying to the architect's having obtained the required continuing education hours. Registrants also shall maintain substantiating information in support of each continuing education claim.

(b) One (1) continuing education hour shall represent a minimum of actual course time. No credit will be allowed for introductory remarks, meals, breaks or administrative matters related to courses of study.

(c) Failure to fulfill the continuing education requirements, or file the required biennial report, properly and completely signed, shall result in non-renewal of an architect's certificate of registration.

(d) Any untrue or false statements or the use thereof with respect to course attendance or any other aspect of continuing education activity is fraud or misrepresentation and will subject the registrant to revocation of registration or other disciplinary action.

(6) Initial registration:

(a) An architect whose initial registration occurs less than twelve (12) months from the December 31st deadline of the next renewal cycle shall not be required to report continuing education hours.

(b) An architect whose initial registration occurs more than twelve (12) months from the December 31st deadline of the next renewal cycle but less than twenty-four (24) months from the date of initial registration shall be required to report twelve (12) contact hours, eight (8) of which shall be in public protection subjects.

(7) Reinstatement: A former registrant [~~,~~] may only apply for reinstatement under 16.30.3.13 NMAC if all delinquent contact hours are earned within the twelve (12) months preceding the application to renew. However, if the total number of contact hours required to become current exceeds twenty-four (24), then twenty-four (24) shall be the maximum number of contact hours required.

(8) Exemptions: A registrant shall be deemed to have complied with the foregoing continuing education requirements if the architect attests in the required affidavit that for not less than twenty-one (21) months of the preceding two-year period of registration, the architect:

(a) has served honorably on active duty in the military service (exceeding ninety (90) consecutive days); or

(b) is a resident of another state or district that accepts New Mexico requirements to satisfy its continuing education requirements, and certifies that all requirements for current continuing education compliance and registration have been met in that jurisdiction; or

(c) is a government employee working as an architect and assigned to duty outside the United States.

(9) The board may consider a hardship case.

(10) Audit: A number of registrants shall be selected at random to submit substantiating information to support their continuing education claim. If any credits are disallowed by the board, then the registrant shall have one hundred and eighty (180) calendar days after notification to substantiate the original claim or obtain other contact hours to meet the minimum requirements. Such contact hours shall not be used again in the next renewal cycle. Additional audits may be conducted at the board's discretion.

(11) Non-compliance: Failure to comply with the requirements of this section shall result in non-renewal of registration and forfeit of the renewal fee.

[16.30.3.11 NMAC - Rp 16 NMAC 30.3.11, 9/6/2001; A, 9/15/2003; A, 4/15/2004; A, 9/16/2004; A, 3/12/2006]

NEW MEXICO DEPARTMENT OF HEALTH

7.14.3 NMAC, Incident Reporting and Investigation Requirements for Providers of Community Based Services, filed 1/10/03 is hereby repealed effective 2/28/06.

NEW MEXICO DEPARTMENT OF HEALTH

TITLE 7 HEALTH
CHAPTER 1 HEALTH GENERAL PROVISIONS
PART 13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS

7.1.13.1 ISSUING AGENCY: New Mexico Department of Health.
[7.1.13.1 NMAC - Rp, 7.14.3.1 NMAC, 02/28/06]

7.1.13.2 SCOPE: This rule is applicable to persons, organizations or legal entities to include: developmental disability waiver, developmental disability general fund, disabled and elderly waiver, medically fragile waiver and traumatic brain injury programs, adult day care center, adult day care home, adult residential care facility, ambulatory surgical center, diagnostic and treatment center, end stage renal disease facility, general, acute, special and limited service hospitals, home health agency, hospice facility, hospital infirmary, intermediate care facility for the mentally retarded, limited diagnostic and treatment center, nursing facility, skilled nursing facility, rural health clinic;
[7.1.13.2 NMAC - Rp, 7.14.3.2 NMAC, 02/28/06]

7.1.13.3 STATUTORY AUTHORITY: Department of Health Act, NMSA 1978 Section 9-7-6 (E) and Section 24-1-2 (D) Sections 24-1-3 (I) (L) (O) (T) (U) and 24-1-5, NMSA 1978, of the Public Health Act as amended.
[7.1.13.3 NMAC - Rp, 7.14.3.3 NMAC, 02/28/06]

7.1.13.4 DURATION: Permanent.
[7.1.13.4 NMAC - Rp, 7.14.3.4 NMAC, 02/28/06]

7.1.13.5 EFFECTIVE DATE: February 28, 2006, unless a later date is cited at the end of a section.
[7.1.13.5 NMAC - Rp, 7.14.3.5 NMAC, 02/28/06]

7.1.13.6 OBJECTIVE: This rule establishes standards for licensed health care facilities and community based service providers to institute and maintain an incident management system and employee training program for the reporting of abuse, neglect and misappropriation of property.
[7.1.13.6 NMAC - Rp, 7.14.3.6 NMAC, 02/28/06]

7.1.13.7 DEFINITIONS:

A. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

B. "Case manager" means the staff person designated to coordinate and monitor the individual service plan for persons receiving community based services.

C. "Complaint" means any report, assertion, or allegation of abuse,

neglect, or misappropriation of a consumer's property made by a reporter to the incident management system, and includes any reportable incident that a licensed health care facility or community based service provider is required to report under applicable law.

D. "CMS" means the centers for medicare and medicaid services.

E. "Community based service providers" means any person, organization or legal entity providing the following services:

(1) "developmental disability general funded services" means a state general funded services for persons with developmental disabilities through contract with the department;

(2) "developmental disability waiver services" means a medicaid funded home or community based services for persons with developmental disabilities;

(3) "disabled & elderly waiver services" means a medicaid funded home or community based services for persons who are elderly or disabled;

(4) "medically fragile waiver services" means a medicaid funded home or community based services for persons who are medically fragile; or

(5) "traumatic brain injury services" means state general funded service or medicaid home or community based services for persons with traumatic brain injury.

F. "Confirmed" means the verification of a complaint based upon a preponderance of reliable evidence obtained from an appropriate investigation of a complaint of abuse, neglect, or exploitation.

G. "Consumer" means any person who engages the professional services of a medical or other health professional on an inpatient or outpatient basis, or person requesting services from a hospital.

H. "Department" means the New Mexico department of health.

I. "Division" means the department of health, division of health improvement, incident management bureau.

J. "Employee" means:

(1) any person whose employment or contractual service with a community based service provider or licensed health care facility which includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that community based service provider or licensed health care facility; or

(2) any compensated persons such as employees, contractors and employees of contractors; or guardianship service providers or case management entities that provide services to people with developmental disabilities; or administrators or operators of facilities who are routinely on site.

K. "Immediate access" means physical or in person direct and unobstructed access, to electronic or other access needed by employees, consumers, family members or legal guardian to the licensed health care facility's or community based service program's incident management reporting procedures or access to the division's incident report form.

L. "Immediate reporting" means reporting that is done as soon as practicable and no later than twenty four hours from knowledge of the incident.

M. "Immediate jeopardy" means a provider's noncompliance with one (1) or more requirements of medicaid or medicare participation, which causes or is likely to cause, serious injury, harm, impairment, or death to a consumer.

N. "Incident" means any known, alleged or suspected event of abuse, neglect, misappropriation of consumers' property and where applicable to community based service providers, unexpected deaths or other reportable incidents.

O. "Incident management system" means the written policies and procedures adopted or developed by the licensed health facility or community based service provider for reporting abuse, neglect, misappropriation of consumers' property and where applicable to community based service providers, unexpected deaths or other reportable incidents.

P. "Incident report form" means the reporting format issued by the division for the reporting of incidents or complaints.

Q. "Licensed health care facilities" means any organization licensed by the department for the following services: adult day care center, adult day care home, adult residential care facility, ambulatory surgical center, diagnostic and treatment center, end stage renal disease facility, general, acute, special and limited service hospitals, home health agency, hospice facility, hospital infirmary, intermediate care facility for the mentally retarded, limited diagnostic and treatment center, nursing facility, skilled nursing facility, rural health clinic.

R. "Misappropriation of property" means the deliberate misplacement of consumer's property, or wrongful, temporary or permanent use of a consumer's belongings or money without the consumer's consent.

S. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

T. "Non-responsible provider" means, any reporter who is reporting an incident in which they are not the responsible community based service provider or licensed health care facility during the time of the incident.

U. "Quality assurance" means a systematic approach to the continuous study and improvement of the efficiency and efficacy of organizational, administrative and clinical practices in meeting the needs of persons served as well as achieving the licensed health care facility's or community based service provider's mission, values and goals.

V. "Quality improvement system" means the adopted or developed licensed health care facility's or community based service provider's policies and procedures for reviewing and documenting all alleged incidents of abuse, neglect, misappropriation of consumers' property and where applicable to community based service providers, unexpected deaths or other reportable incidents for the continuous study and improvement of the efficiency and efficacy of organizational, administrative and preventative practices in employee training and reporting.

W. "Reporter" means any person who or any entity that reports possible abuse, neglect or misappropriation to the department's incident management system.

X. "Restraints" means use of a mechanical device, or chemical restraints imposed, for the purposes of discipline or convenience, to physically restrict a consumer's freedom of movement, performance of physical activity, or normal access to his body.

Y. "Revocation" means a type of sanction making a license null and void through its cancellation.

Z. "Sanction" means a measure imposed by the department on a licensed or contract program, pursuant to these requirements, in response to a finding of deficiency, with the intent of obtaining increased compliance with these requirements.

AA. "Suspension" means a temporary cancellation of a license pending an appeal, hearing or correction of the deficiency. During a suspension the provider's medicare or medicaid agreement is not in effect.

BB. "Training curriculum" means the instruction manual or pamphlet adopted or developed by the licensed health facility or community based service provider containing policies and procedures for reporting abuse, neglect, misappropriation of consumers' property and where applicable to community based service providers, unexpected deaths or other reportable incidents.

CC. "Volunteer" means

any person who works without compensation for a community based service provider or licensed health care facility whose services includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that community based service provider or licensed health care facility.
[7.1.13.7 NMAC - Rp, 7.14.3.7 NMAC, 02/28/06]

7.1.13.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR LICENSED HEALTH CARE FACILITIES:

A. Duty To Report:

(1) All licensed health care facilities shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.

(2) All licensed health care facilities shall report abuse, neglect, misappropriation of property, and injuries of unknown sources to the division within a twenty-four (24) hour period.

(3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.

B. Notification:

(1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident either independently or through the licensed health care facility to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number (insert toll free number).

(2) Division Incident Report Form and Notification by Licensed Health Care Facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.

C. Incident Policies: All licensed health care facilities shall maintain policies and procedures which describes the licensed health care facility's immediate response to all reported allegations of incidents involving abuse, neglect, misappropriation of consumer property, injuries of unknown sources, and deaths, as applicable.

D. Retaliation: Any individual who, without false intent, reports an incident or makes an allegation of abuse, neglect or exploitation will be free of any form of retaliation.

F. Quality Improvement System for Licensed Health Care Facilities: The licensed health care facility shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents.
[7.1.13.8 NMAC - N, 02/28/06]

7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:

A. Duty To Report:

(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.

(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include:

(a) an environmental hazardous condition, which creates an immediate threat to life or health; or

(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.

(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.

B. Notification:

(1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number (1-800-797-3260).

(2) Division Incident Report Form and Notification by Community Based Service Providers: The community based service provider shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.

(3) Legal Guardian or Parental Notification by Reporter: The community based service provider shall ensure that an alleged incident is reported concurrently with the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday to the consumer's legal guardian or family member if the consumer is a minor. Exception. If the parents or legal guardian are suspected of committing the alleged abuse, neglect or misappropriation of property the community based service provider will defer the matter to the division's investigative representative.

(4) Case Manager Notification by Community Based Service Providers: Community based service providers shall notify the consumer's case manager that an alleged incident involving abuse, neglect, or misappropriation of property has occurred and been reported to the division within twenty-four (24) hours of an alleged incident or the next business day if the incident occurs on a weekend or a holiday. It is acceptable to redact names of other consumers and employees before the document is forwarded to a case manager.

(5) Non-responsible Reporter: Reporters who are reporting an incident in which they are not the responsible community based service provider shall notify the responsible community based service provider concurrently with the division within twenty-four (24) hours of an incident or allegation of an incident or the next busi-

ness day if the incident occurs on a weekend or a holiday.

(6) Community Based Service Providers Notification of Law Enforcement Intervention: The community based service provider shall report to the division all instances of law enforcement intervention that results in the arrest or detention of a consumer which involves an incident, as defined by this rule, within twenty-four (24) hours of occurrence.

C. Incident Policies: All community based service providers shall maintain policies and procedures, which describe the community based service provider's immediate response to all reported allegations of incidents involving abuse, neglect, or misappropriation of property; all unexpected deaths or natural/expected deaths, and other reportable incidents required as required in Paragraph (2) of Subsection A of 7.1.13.9 NMAC.

D. Retaliation: Any individual who, without false intent, reports an incident or makes an allegation of abuse, neglect or exploitation will be free of any form of retaliation.

E. Quality Improvement System for Community Based Service Providers: The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;

(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;

(3) community based service providers providing services under the disabled & elderly waiver must have current incident management policy and procedures in place, which comply with department's current requirements;

(4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.

[7.1.13.9 NMAC - N, 02/28/06]

7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:

A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.

B. Training Curriculum: The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider's facility. Training shall be conducted in a language that is understood by the employee and volunteer.

C. Incident Management System Training Curriculum Requirements:

(1) The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum that includes but is not limited to:

(a) an overview of the potential risk of abuse, neglect, misappropriation of consumers' property;

(b) informational procedures for properly filing the division's incident management report form;

(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property.

(d) specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property;

(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and

(f) where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents.

(2) All current employees shall receive training within ninety (90) days of the effective date of this rule.

(3) All new employees shall receive training within thirty (30) days of the employees initial hire date.

D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.

E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.

F. Posting of Incident Management Information Poster: All licensed health care facilities and community based service providers shall post two (2) or more posters, to be furnished by the division, in a prominent public location which

states all incident management reporting procedures, including contact numbers and Internet addresses. All licensed health care facilities and community based service providers operating sixty (60) or more beds shall post three (3) or more posters, to be furnished by the division, in a prominent public location which states all incident management reporting procedures, including contact numbers and Internet addresses. The posters shall be posted where employees report each day and from which the employees operate to carry out their activities. Each licensed health care facility or community based service provider shall take steps to insure that the notices are not altered, defaced, removed, or covered by other material.
[7.1.13.10 NMAC - N, 02/28/06]

7.1.13.11 ACCESS AND COOPERATION TO FACILITATE DEPARTMENT INCIDENT INVESTIGATIONS:

A. The department will conduct incident investigations and periodic quality assurance reviews of licensed health care facilities and community based service providers subject to these requirements. These reviews may be either announced or unannounced in accordance with the procedures set forth in 7.1.12 NMAC.

B. All health care facilities and community based service providers programs shall facilitate immediate physical or in-person access to department personnel investigating incidents or conducting quality assurance reviews:

(1) all records, regardless of media, including but not limited to, financial records, all client records, individual service plans, IFSPs, personnel records, board and or committee minutes, incident reports, quality assurance activities, client satisfaction surveys and agency policy /procedures manuals;

(2) all necessary employees with direct knowledge of the incident;

(3) all necessary clients currently receiving services, guardians, representatives and family members with direct knowledge of the incident; and

(4) all administrative and service delivery sites.
[7.1.13.11 NMAC - Rp, 7.14.3.12 NMAC, 02/28/06]

7.1.13.12 CONSEQUENCES OF LICENSED HEALTH CARE FACILITIES OR COMMUNITY BASED SERVICE PROVIDER NON-COMPLIANCE:

A. The department or other governmental agency having regulatory enforcement authority over a licensed health care facility or community based service provider may sanction a licensed health care facility or community based service provider in accordance with applicable law if the licensed health care facility or community based service provider fails to report incidents of abuse, neglect or misappropriation of consumers property or fails to provide or fails to maintain evidence of an existing incident management system and employee training documentation as set forth by this rule.

B. Such sanctions may include revocation or suspension of license, directed plan of correction, intermediate sanctions or civil monetary penalty up to five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.

C. All confirmed incident investigations conducted by the department hold the licensed health care facility or community based service provider responsible for the actions of the employee in their employment with the following exception. Any employee found to have cause the abuse, neglect or misappropriation of consumer property, shall be held accountable independent of the licensed health care facility or community based service provider. This exception applies only when the licensed health care facility or community based service provider has complied with all requirements of this rule and the employee acts outside of the provided system. When this occurs the employee shall be subject to the Employee Abuse Registry Act, Sections 29.27.1 - 8 NMSA (2005).
[7.1.13.12 NMAC - Rp, 7.14.3.11 NMAC, 02/28/06]

7.1.13.13 CONFIDENTIALITY: All consumer information reviewed or obtained in the course of quality assurance reviews of a licensed health care facility or community based service provider is confidential in accordance with all applicable federal and state law and regulation and with all applicable contract provisions. Other confidential information includes, but is not limited to: identity of the incident report form reporter, personnel records, the licensed health care facility's or community based service provider's internal incident investigations, financial documents and proprietary business information.
[7.1.13.13 NMAC - Rp, 7.14.3.10 NMAC, 02/28/06]

7.1.13.14 SEVERABILITY: If any provision or application of 7.1.13 NMAC is held invalid, the remainder, or its application to other situations or persons, shall not be affected.
[7.1.13.14 NMAC - N, 02/28/06]

HISTORY OF 7.1.13 NMAC:
Pre-NMAC History: None.

History of Repealed Material: 7.14.3 NMAC, Incident Reporting and Investigation Requirements for Providers of Community Based Services (filed 01/10/03) repealed 02/28/06.

NMAC History:
7.14.3 NMAC, Incident Reporting and Investigation Requirements for Providers of Community Based Services (filed 01/10/03) was renumbered and replaced by 7.1.13 NMAC, Incident Reporting, Intake, Processing and Training Requirements, effective 02/28/06.

NEW MEXICO
DEPARTMENT OF HEALTH

This is an amendment to 7.1.7 NMAC Sections 5, 10, 11 and 12, effective 2/28/06. This rule has also been renumbered and reformatted to comply with current NMAC requirements.

7.1.7.5 EFFECTIVE DATE: October 31, 1996, unless a [~~different~~] later date is cited at the end of a section [~~or paragraph~~].
[10/31/96; 7.1.5 NMAC - Rn & A, 7 NMAC 1.7.5, 2/28/06]

7.1.7.10 HEALTH FACILITY INITIAL APPLICATION PROCESSING FEE SCHEDULE:

A. CATEGORY I. Fees for facilities providing professional medical or nursing services in the home or on an outpatient basis shall be based on the initial application rate:

TYPE OF FACILITY	Rate Per Initial Application
Ambulatory Surgical Center	$ 100.00
Community Mental Health	$ 100.00

Diagnostic and Treatment Center . . . . . .$ 100.00
Free Standing Hospice . . . . . $ 100.00
Home Health Agency . . . . . $ 100.00
Infirmary . . . . . $ 100.00
Limited Diagnostic and Treatment Center . . . . . $ 100.00
New or Innovative Clinic . . . . . $ 100.00
Rural Health Clinic . . . . . $ 100.00
Services for End State Renal Disease . . . . . .$ 100.00
Renal Treatment Center . . . . . .$ 100.00
Renal Dialysis Center. . . . . $ 100.00
Renal Dialysis Facility . . . . . $ 100.00
Self-Dialysis Unit . . . . . $ 100.00
Special Purpose Renal Dialysis Facility . . . . . $ 100.00

B. CATEGORY II. Fees for facilities providing residential care and services on a twenty-four (24) hour basis shall be based on the number of beds in each facility;

TYPE OF FACILITY
Adult Boarding Home
Adult Residential Shelter Care Home
Community Residential Facility for Developmentally
Disabled Individuals
Family Care Home
Half Way Home
New or Innovative Programs
Residential Treatment Homes

Application Rate According to Facility Size
2 - 29 . . . . . $ 50.00
30 - 50 . . . . . .$ 50.00
51 - 100 . . . . . $ 50.00
101 - 150 . . . . . $ 75.00
151 - 200 . . . . . $ 75.00
200 + ... $ 75.00

C. CATEGORY III. Fees for facilities providing care and services for less than twenty four (24) hours a day shall be based on the initial application:

TYPE OF FACILITY	**Rate Per Initial Application**
Adult Day Care Centers	$ 25.00
Adult Day Care Home	$ 25.00
New or Innovative Programs Providing Adult Day Care	$ 25.00

[7.1.7.10 NMAC - N, 2/28/06]

[~~7.1.7.10~~] 7.1.7.11 FEE SCHEDULE: Rates shall be charged, as indicated in the fee schedule shown in this Section, upon initial and renewal application for an annual license and prior to issuance of a second temporary license. The fee for the first temporary license is covered by the fee paid upon application for an annual license.

A. CATEGORY I: Fees for facilities providing professional medical or nursing services on a twenty-four (24) hour basis shall be based on the number of beds in each facility:

TYPE OF FACILITY	**RATE PER BED**
General hospital	[~~$ 3.00~~] $ 6.00
Limited hospitals	$ 6.00
Special hospital	[~~$ 3.00~~] $ 6.00
orthopedic hospitals	[~~$ 3.00~~] $ 6.00
children's' hospitals	[~~$ 3.00~~] $ 6.00
psychiatric hospitals	[~~$ 3.00~~] $ 6.00
alcohol and drug abuse treatment hospitals	[~~$ 3.00~~] $ 6.00
rehabilitation hospitals	[~~$ 3.00~~] $ 6.00
(NOTE: other special hospitals as identified)	
Children's Psychiatric Hospital	$ 6.00
Rural primary care hospitals	[~~$ 3.00~~] $ 6.00
Long-term care facilities	[~~$ 3.00~~] $ 6.00
skilled nursing facilities	
intermediate care facilities	

B. CATEGORY II: Fee for facilities providing professional medical or nursing services in the home or on an outpatient basis shall be based per license for each facility:

TYPE OF FACILITY	**RATE PER LICENSE**
Health facilities providing outpatient medical services	[~~$55.00~~] $100.00
~~[ambulatory surgical center]~~	
community mental health	$ 100.00
free standing hospice	$ 100.00

home health agency . . . . . $ 100.00
diagnostic and treatment center . . . . . $ 100.00
limited diagnostic and treatment center . . . . . $ 100.00
rural health clinic . . . . . $ 100.00
infirmary . . . . . $ 100.00
new or innovative clinic . . . . . $ 100.00
ambulatory surgical center . . . . . $ 150.00
Facilities providing services for end stage renal disease . . . . . [~~$55.00~~] $ 100.00
services for end state renal disease . . . . . $ 100.00
renal treatment center . . . . . $ 100.00
renal transplantation center . . . . . $ 100.00
renal dialysis center . . . . . $ 100.00
renal dialysis facility . . . . . $ 100.00
self dialysis unit . . . . . $ 100.00
special purpose renal dialysis facility . . . . . $ 100.00
In home and inpatient hospice care . . . . . [~~$55.00~~] $ 100.00
Home health agencies . . . . . [~~$55.00~~] $ 100.00

C. CATEGORY III: Fees for facilities providing residential care and services on a twenty-four (24) hour basis shall be based on the number of beds in each facility:

TYPE OF FACILITY	[~~**RATE PER LICENSE**~~]
Residential shelter care and boarding home facilities for adults	[~~$30.00~~]
Shelter care facilities	
adult residential shelter care home	
community residential facility for adult developmentally disabled individuals	
residential treatment home	
Boarding home facilities	
boarding home	
half way home	
Family care home	
New or innovative programs	

Rate Per Number of Bed	
2 - 29	$ 100.00
30 - 50	$ 125.00
51 - 100	$ 150.00
101 - 150	$ 175.00
151 - 200	$ 200.00
201 +	$ 225.00

D. CATEGORY IV: Facilities providing care and services for less than twenty-four (24) hours a day.

TYPE OF FACILITY	**RATE PER LICENSE**
Facilities providing adult day care	
adult day care center	[~~$55.00~~] $ 75.00
adult day care home	[~~$15.00~~] $ 25.00
new or innovative programs providing adult day care	[~~$55.00~~] $ 75.00

[11/20/85, 10/18/91, 4/30/93; 7.1.7.11 NMAC - Rn, 7 NMAC 1.7.10 & A, 2/28/06]

[~~7.1.7.11~~] 7.1.7.12 FEES FOR AMENDED LICENSES: The licensing fee for each amended license issued shall be forty ($40.00) dollars with the exception of the facilities listed below whose licensing fee for amended license will be as indicated.

TYPE OF FACILITY	**AMENDED LICENSE FEE**
Change of administrator or director	$ 40.00
Change of capacity (additional $3.00 per bed if fee is rate per bed)	$ 40.00
Change of facility name	$ 40.00
Exception:	
Family day care home	[~~$5.00~~] $ 10.00
Group day care home	[~~$5.00~~] $ 10.00
Adult day care home	[~~$5.00~~] $ 10.00

[11/20/85, 1/18/91, 4/30/93; 7.1.7.12 NMAC - Rn, 7 NMAC 1.7.11 & A, 2/28/06]

NEW MEXICO DEPARTMENT OF HEALTH

This is an amendment to 7.11.2 NMAC Sections 2, 5, 6, 7, 9, 15, 17, 22, 23, 24, 28, 32, 34, 49, 51, 54, 55, 57, 60, 63, 64, 65,66, 67, 70 and 71, effective 2/28/06. This rule has also been renumbered and reformatted to comply with current NMAC requirements.

7.11.2.2 SCOPE:

A. These regulations apply to the following:

(1) public, profit or nonprofit outpatient facilities, ambulatory surgical centers, diagnostic and treatment centers, or infirmaries, providing services as outlined by these regulations; or

(2) any facility providing services as outlined by these regulations which by federal regulation must be licensed by the state of New Mexico to obtain or maintain full or partial, permanent or temporary federal funding.

B. These regulations do not apply to the following: offices and treatment rooms of licensed private practitioners.

[9/1/56, 7/1/60, 6/27/90; 7.11.2.2 NMAC - Rn & A, 7 NMAC 11.2.2, 02/28/06]

7.11.2.5 EFFECTIVE DATE: October 31, 1996, unless a [~~different~~] later date is specified at the end of a section [~~or Paragraph~~].

[10/31/96; 7.11.2.5 NMAC - Rn & A, 7 NMAC 11.2.5, 02/28/06]

7.11.2.6 OBJECTIVE:

A. Establish minimum standards for licensing of health facilities who provide outpatient medical services and infirmaries.

B. Monitor health facilities providing outpatient medical services and infirmaries with these regulations through surveys to identify any areas which could be dangerous or harmful to the patients or staff.

C. Encourage the establishment and maintenance of health facilities to provide outpatient medical services and infirmaries to the citizens of New Mexico that provide quality services that [~~maintain~~] maintains or [~~improve~~] improves the health and quality of life to the patients.

[9/1/56, 7/1/60, 6/27/90; 7.11.2.6 NMAC - Rn & A, 7 NMAC 11.2.6, 02/28/06]

7.11.2.7 DEFINITIONS: [~~For purposes of these regulations the following shall apply:~~]

A. "Applicant" means the individual who, or organization which, applies for a license; if the applicant is an organization, then the individual signing the

application on behalf of the organization must have authority from the organization; the applicant must be the owner.

B. "Certified registered nurse anesthetist" means an advanced practice professional registered nurse permitted by law to provide anesthesia care; in an interdependent role as a member of a health care team in which medical care of the patient is directed by a medical physician, osteopathic physician, dentist or podiatrist licensed in the state of New Mexico; the certified registered nurse anesthetist shall collaborate with the medical physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care or the patient; collaboration means the process in which each health care provider contributes their respective expertise.

[B.]C. "Deficiency" means a violation of or failure to comply with a provision(s) of these regulations.

[C.]D. "Dentist" means a person licensed to practice dentistry in the state of New Mexico under the Dental Act, Sections 61-5-1 to 61-5-22 NMSA 1978.

[D.]E. "Department" means the New Mexico department of health.

[E.]F. "Facility" means a building or buildings in which outpatient medical services are provided to the public and which is licensed pursuant to [these regulations] this rule.

[F.]G. "Governing body" means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control and management of the activities and functions of a facility licensed pursuant to these regulations.

[G.]H. "License" means the document issued by the licensing authority pursuant to these regulations granting the legal right to operate for a specified period of time, not to exceed one (1) year.

[H.]I. "Licensed practical nurse" means a person licensed as a trained practical nurse under the Nursing Practice Act, Section 61-3-19 NMSA 1978.

[I.]J. "Licensee" means the person(s) who, or organization which, has an ownership, leasehold, or similar interest in the facility and in whose name a license for a facility has been issued and who is legally responsible for compliance with these regulations.

[J.]K. "Licensing authority" means the New Mexico department of health.

[K.]L. "NMSA" means the New Mexico Statutes Annotated, 1978 compilation, and all the revisions and compilations thereof.

[L.]M. "Physician" means a person licensed to practice medicine or osteopathy by the New Mexico board of medical examiners, pursuant to Section 61-6-10 NMSA 1978 or the osteopathic medical examiners board pursuant to Sections 61-10-1 through 61-10-21, NMSA 1978.

[M.]N. "Physician's assistant" means a person licensed as a physician's assistant by the New Mexico board of medical examiners, in accordance with Section 61-6-6 NMSA 1978.

[N.]O. "Plan of correction" means the plan submitted by the licensee or representative of the licensee addressing how and when deficiencies identified at time of a survey will be corrected.

[O.]P. "Policy" means a statement of principle that guides and determines present and future decisions and actions.

[P.]Q. "Premises" means all parts of buildings, grounds, and equipment of a facility.

[Q]R. "Procedure" means the action(s) that must be taken in order to implement a policy.

[R.]S. "Registered nurse" means a person who holds a certificate of registration as a registered nurse under the Nursing Practice Act, Sections 61-3-1 to 61-3-30 NMSA 1978.

[S.]T. "Resident" as defined in Section 3 (I) of the Resident Abuse and Neglect Act means any person who receives treatment from a health facility.

[T.]U. "U/L approved" means approved for safety by the national underwriters laboratory.

[U.]V. "Variance" means an act on the part of the licensing authority to refrain from pressing or enforcing compliance with a portion or portions of these regulations for an unspecified period of time where the granting of a variance will not create a danger to the health, safety, or welfare of patients or staff of a facility, and is at the sole discretion of the licensing authority.

[V.]W. "Waive or waiver" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of the patients and staff are not in danger; waivers are issued at the sole discretion of the licensing authority.

[9/1/56, 7/1/60, 6/27/90, 10/31/96; 7.11.2.7 NMAC - Rn & A, 7 NMAC 11.2.7, 02/28/06]

7.11.2.9 TYPES OF FACILITIES AND SCOPE OF SERVICES:

A. Ambulatory surgical center: means any distinct entity that operates exclusively for the purpose of providing surgical services without anticipation of overnight stay of patients. This type of facility may be integrated with the surgical department of an existing hospital and its outpatient department utilizing many of their services and resources. Those facilities which are freestanding may provide some services such as specialized diagnostic and laboratory by agreement or contract with another health care provider.

B. Diagnostic and treatment center: means a facility which provides a service to the public on an outpatient basis for the diagnosis and treatment of medical conditions not requiring hospitalization. Services provided are those diagnostic and therapeutic services commonly furnished in a physician's office or at the entry point into the health care delivery system. These include medical history, physical examination, assessment of health status and treatment for a variety of medical conditions.

C. Limited diagnostic and treatment center: means a facility which provides on an outpatient basis a limited scope of services. This type of facility provides services usually in only one or two areas of preventive health, such as family planning, hypertension, child health, prenatal, dental health etc; their services rely heavily on consultation, referral and counseling. Because of their limited scope of services and amounts of medical supplies and equipment less stringent standards in building and fire codes are permitted.

D. Rural health clinic: means a facility which provides services to the public in a rural area where there is a limited population and a shortage of physicians and other health care providers. Services are the same as those of a diagnostic and treatment center which are normally provided by a physician, but in a rural health clinic may be provided by a nurse practitioner or a physician's assistant. Facilities licensed as a rural health clinic must be located in a geographic area in which it has been determined by the New Mexico department of health or federal government, through the use of indices and other standards set by them, that a shortage of physicians and health care personnel exist to provide primary health care to the citizens of that area.

E. Infirmary: is a short term emergency medical and nursing care facility of an educational institution which in conjunction with providing diagnostic and treatment services to the members, has on a continuing 24-hour basis, inpatient facilities and resources for short-term emergency medical and nursing care.

F. New or innovative clinic: When a professional organization has shown a need for a new or innovative type of outpatient service which does not fit into one of the categories of Subsections A through E of 7.11.2.9 NMAC of these regu-

lations, it may be licensed at the sole discretion of the licensing authority, if all requirements outlined in 7.11.2.10 NMAC below have been met.
[9/1/56, 7/1/60, 6/27/90; 7.11.2.9 NMAC - Rn & A, 7 NMAC 11.2.9, 02/28/06]

7.11.2.15 AUTOMATIC EXPIRATION OF LICENSE: A license will automatically expire at midnight on the day indicated on the license as the expiration date, unless sooner renewed, suspended, or revoked: or

A. on the day a facility discontinues operation; or

B. on the day a facility is sold, leased, or otherwise changes ownership and/or license; or

C. on the day a facility changes location.
[9/1/56, 7/1/60, 7/1/64, 6/27/90, 10/31/96; 7.11.2.15 NMAC - Rn & A, 7 NMAC 11.2.15, 02/28/06]

7.11.2.17 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following:

A. failure to comply with any provision of these regulations;

B. failure to allow survey by authorized representatives of the licensing authority;

C. any person active in the operation of a facility licensed pursuant to these regulations shall not be under the influence of alcohol or narcotics or convicted of a felony;

D. misrepresentation or falsification of any information on application forms or other documents provided to the licensing authority;

E. discovery of repeat violations of these regulations during surveys; or

F. failure to provide the required care and services as outlined by these regulations for the patients receiving care at the facility.
[9/1/56, 7/1/60, 7/1/64, 6/27/90, 10/31/96; 7.11.2.17 NMAC - Rn & A, 7 NMAC 11.2.17, 02/28/06]

7.11.2.22 REPORTING OF INCIDENTS: All facilities licensed pursuant to these regulations must report to the licensing authority any serious incident or unusual occurrence which has, or could threaten the health, safety, and welfare of the patients or staff, such as but not limited to:

A. fire, flood, or other natural disaster which creates structural damages to the facility or poses health hazards;

B. any serious outbreak of contagious diseases dangerous to the public health;

C. any serious human errors by staff members of the facility which has resulted in the death, serious illness, or physical impairment of a patient; or

D. in accordance with Section 8A of the "Resident, Abuse, and Neglect Act".
[6/27/90, 10/31/96; 7.11.2.22 NMAC - Rn & A, 7 NMAC 11.2.22, 02/28/06]

7.11.2.23 QUALITY ASSURANCE: All facilities licensed pursuant to these regulations must have an ongoing, comprehensive self-assessment of the services provided by the facility. The assessment must include the total operation of the facility.

A. To be considered comprehensive the assessment for quality assurance must include, but is not limited to the following:

(1) condition of patients and services rendered;

(2) completeness of patient records;

(3) organization of the facility;

(4) administration;

(5) staff utilization and training; and

(6) policies and procedures.

B. Where problems (or potential problems) are identified, the facility must act as soon as possible to avoid any risks to patients such as, but not limited to the following:

(1) changes in policies and procedures;

(2) staffing and assignment changes;

(3) additional education and training for the staff;

(4) changes in equipment or physical plant; or

(5) deletion or addition of services.

C. The governing body of the facility shall ensure that the effectiveness of the quality assurance program is evaluated by medical and administrative staff at least once a year. If the evaluation is not done all at once, no more than a year must lapse between [~~evaluation~~] evaluations of the same parts.

D. Documentation of the quality assurance program must be maintained by the facility.
[6/27/90; 7.11.2.23 NMAC - Rn & A, 7 NMAC 11.2.23, 02/28/06]

7.11.2.24 PATIENT RECORDS: Each facility licensed pursuant to these regulations must maintain a medical record for each patient. Every record must be accurate, legible and promptly completed. Medical records must include at least the following:

A. **ambulatory surgical centers:**

(1) patient identification;

(2) significant medical history and results of physical examination;

(3) pre-operative diagnostic studies (entered before surgery), if performed;

(4) findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body;

(5) any allergies and abnormal drug reactions;

(6) entries related to anesthesia administration;

(7) documentation of properly executed informed patient consent; and

(8) discharge diagnosis;

B. **diagnostic and treatment centers, rural health clinics, limited diagnostic and treatment centers:**

(1) patient identification;

(2) patient consent forms (if applicable);

(3) pertinent medical history;

(4) assessment of the health status and health care needs of the patient;

(5) brief summary of the episode for which the patient is requiring care;

(6) disposition, and instructions to the patient;

(7) reports of physical examinations, diagnostic and laboratory test results, and consultative findings; and

(8) all physician's orders, reports of treatments and medication and other pertinent information necessary to monitor the patient's progress;

C. **infirmaries:**

(1) same as Paragraphs (1) through (8) of Subsection B of 7.11.2.24 NMAC above;

(2) nursing notes (for those patients requiring overnight care or observation); and

(3) medication chart (if applicable);

D. **new or innovative outpatient service:**

(1) same as Paragraphs (1) through (8) of Subsection B of 7.11.2.24 NMAC] above;

(2) any other information deemed necessary by the licensing authority after review and approval of the new or innovative service.
[9/1/56, 7/1/60, 6/27/90; 7.11.2.24 NMAC - Rn & A, 7 NMAC 11.2.24, 02/28/06]

7.11.2.28 POLICIES AND PROCEDURES:

A. All facilities licensed pursuant to these regulations must have written policies and procedures for the following:

(1) quality assurance program;

(2) maintenance of building and equipment;

(3) fire and evacuation;

(4) staff development and evaluation;

(5) administration and preparation of drugs;

(6) referral of patients.

B. Ambulatory Surgical Center: In addition to those policies and procedures listed in Subsection A of 7.11.2.28 NMAC of these regulations, ambulatory surgical centers must have the following policies and procedures:

(1) transfer of patients to hospital for patients requiring emergency care;

(2) for ambulance services if applicable;

(3) transfer of medical information;

(4) resuscitative techniques;

(5) aseptic techniques and scrub procedures;

(6) care of surgical specimens;

(7) protocols of surgical procedures;

(8) cleaning of operating room after each use;

(9) sterilization and disinfection;

(10) operating room attire;

(11) care of anesthesia equipment;

(12) special provision for infected or contaminated patients; and

(13) inspection and maintenance of emergency equipment in operating room.

C. Infirmaries: In addition to those policies and procedures listed in Subsection A of 7.11.2.28 NMAC of these regulations, infirmaries must have the following policies and procedures:

(1) inpatient care;

(2) transfer of patients to hospital.

D. New or Innovative Outpatient Services: In addition to those policies and procedures listed in Subsection A of 7.11.2.28 NMAC of these regulations, may have others required by the licensing authority after review of program and approval of the new or innovative service.

[6/27/90; 7.11.2.28 NMAC - Rn & A, 7 NMAC 11.2.28, 02/28/06]

7.11.2.32 WATER:

A. A facility licensed pursuant to these regulations must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system must be inspected, tested, and approved by the New Mexico environment department prior to licensure. It is the facility's responsibility to insure that subsequent periodic testing or inspection of such private water systems be made at intervals prescribed by the New Mexico environment department or recognized authority.

C. Hot and cold running water under pressure must be distributed at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

D. Backflow preventors (vacuum breakers) must be installed on hose [~~bibbs~~] bibs, laboratory sinks, janitor's sinks, and on all other water fixtures to which hoses or tubing can be attached.

E. Water distribution systems are arranged to provide hot water at each hot water outlet at all times. Hot water to hand washing facilities must not exceed 120 degrees F.

[9/1/56, 7/1/60, 7/1/64, 6/27/90, 10/31/96; 7.11.2.32 NMAC - Rn & A, 7 NMAC 11.2.32, 02/28/06]

7.11.2.34 FIRE SAFETY COMPLIANCE: All current applicable [~~requirement~~] requirements of state and local codes for fire prevention and safety must be met by the facility.

[9/1/56, 6/27/90; 7.11.2.34 NMAC - Rn & A, 7 NMAC 11.2.34, 02/28/06]

7.11.2.49 RADIOLOGY:

A. All facilities licensed pursuant to these regulations which provide [~~radiologie~~] radiological services to include portable and dental units must meet the requirements of the New Mexico environment department for installation and use of the [~~radiologie~~] radiological equipment.

B. For those facilities providing [~~radiologie~~] radiological services the following is required:

(1) radiographic room meeting the requirements as stated in Subsection A of 7.11.2.49 NMAC above;

(2) film processing facilities;

(3) storage facilities for exposed film;

(4) toilet room with hand washing facilities accessible to fluoroscopy room(s), if fluoroscopic procedures are part of the services; and

(5) dressing rooms or booths, as required by services provided with convenient toilet access.

[6/27/90, 10/31/96; 7.11.2.49 NMAC - Rn & A, 7 NMAC 11.2.49, 02/28/06]

7.11.2.51 EXITS:

A. Each facility and each floor of a facility shall have exits as required/permitted by national fire protection association 101 (life safety code).

B. Each exit must be marked by illuminated signs having letters at least six (6) inches high whose principle strokes are at least three-fourths (3/4) of an inch wide. Exception: Limited diagnostic and treatment centers may in some cases not be required to have the illuminated exit signs but may use non-illuminated signs meeting the requirements as shown above.

C. Illuminated exit signs must be maintained in operable condition at all times.

D. Exit ways must be kept free from obstructions at all times.

E. Exit doors:

(1) Exit doors to all exit or exit access doors must be at least 36" wide.

(2) Ambulatory surgical centers [~~who~~] that use general anesthesia or have patients on life support equipment must have exit doors 44" in width.

[9/1/56, 7/1/60, 7/1/64, 6/27/90; 7.11.2.51 NMAC - Rn & A, 7 NMAC 11.2.51, 02/28/06]

7.11.2.54 COMMON ELEMENTS FOR [~~OUTPATIENT~~] OUTPATIENTS FACILITIES: The following shall apply to each outpatient facility, with additions and/or modifications as noted for each specific type of outpatient facility in other sections of these regulations or not applicable based on scope of services provided by the facility. Administration and public areas:

A. Entrance shall be able to accommodate wheelchairs.

B. Public services shall include:

(1) conveniently accessible wheelchair storage;

(2) a reception and information counter or desk;

(3) waiting areas: where an organized pediatric service is provided by the outpatient facility, provisions shall be made for separating pediatric and adult patients;

(4) conveniently accessible public toilets;

(5) conveniently accessible drinking fountain(s).

C. Interview space(s) for private interviews related to social service, medical information, etc., shall be provided.

D. General or individual office(s) for business transactions, records, administrative, and professional staff shall be provided.

E. Clerical space or rooms for typing, clerical work, and filing, separated from public areas for confidentiality,

shall be provided.

F. Special storage for staff personal effects with locking drawers or cabinets (may be individual desks or cabinets) shall be provided. Such storage shall be near individual work stations and staff controlled.

G. General storage facilities for supplies and equipment shall be provided.

H. Nurses station(s) shall have a work counter, communication system, space for supplies, and provisions for charting.

I. Drug distribution station which may be part of the nurses station and shall include a work counter, sink, refrigerator, and locked storage for biologicals and drugs.

J. Clean storage consisting of a separate room or closet for storing clean and sterile supplies shall be provided and shall be in addition to that of cabinets and shelves.

K. Soiled holding which provides for separate collection, storage, and disposal of soiled materials.

L. Sterilizing procedures may be done on or off site, or disposables may be used to satisfy functional needs.

[9/1/56, 7/1/60, 6/27/90; 7.11.2.54 NMAC - Rn & A, 7 NMAC 11.2.54, 02/28/06]

7.11.2.55 LABORATORY: Facilities licensed pursuant to these regulations that [~~provides~~] provide laboratory services must provide the following:

A. laboratory work counter(s) with sink, and electric services;

B. lavatory(ies) or counter sink(s) equipped for hand washing;

C. storage cabinet(s) or closet(s);

D. specimen collection facilities with a toilet and lavatory;

E. blood collection facilities shall have seating space, a work counter, and hand washing facilities.

[9/1/56, 7/1/60, 6/27/90; 7.11.2.55 NMAC - Rn & A, 7 NMAC 11.2.55, 02/28/06]

7.11.2.57 EXAMINATION ROOMS:

A. **General Purpose Examination Rooms:** For medical, obstetrical, and similar examinations shall meet the following requirements:

(1) minimum floor area of eighty (80) square feet, excluding vestibules, toilets, and closets;

(2) room arrangement shall permit at least two (2) feet eight (8) inches clearance at each side and at the foot of the examination table;

(3) a lavatory or sink for hand washing; and

(4) a counter or shelf space for writing.

B. **Special Purpose Examination Rooms:** For special examination such as eye, ear, nose, throat, and dental (if provided), shall meet the following requirements:

(1) floor area sufficient to accommodate procedures and equipment used but in no case less than eighty (80) square feet, excluding vestibules, toilets, and closets;

(2) a lavatory or sink for hand washing;

(3) a counter or shelf space for writing.

[9/1/56, 7/1/60, 6/27/90; 7.11.2.57 NMAC - Rn & A, 7 NMAC 11.2.57, 02/28/06]

7.11.2.60 SPECIAL REQUIREMENTS FOR AMBULATORY SURGICAL CENTERS: In addition to all other requirements contained in these regulations ambulatory surgical centers will provide the following.

A. A covered entrance for pickup of patients after surgery.

B. A medical records room equipped for recording, and retrieval of medical records.

C. At least one examination or treatment room meeting the requirements outlined in Sections 57 and 58 of 7.11.2 NMAC shall be provided for examination and testing of patients prior to surgery.

D. **Operating Rooms or Surgical Suites.**

(1) Each operating room will have a minimum clear area of at least two hundred-fifty (250) square feet.

(2) An emergency communication system connected with the surgical control station shall be provided.

(3) At least one x-ray film illuminator shall be provided in each operating room.

(4) Closed storage space for splints and traction equipment shall be provided for orthopedic surgery.

(5) Room(s) for post-anesthesia recovery of outpatient surgical patients shall be provided meeting the following requirements:

(a) at least three (3) feet shall be provided at each side and at the foot of each bed as needed for work and/or circulation;

(b) if pediatric surgery is part of the services, separation from the adult section and space for parents shall be provided.

(6) A designated supervised recovery lounge shall be provided for patients who do not require post-anesthesia recovery but need additional time for their vital signs to stabilize before safely leaving the facility. This lounge shall contain:

(a) control station;

(b) space for family members;

(c) provisions for privacy; and

(d) convenient patient access to toilets large enough to accommodate patient, wheelchair, and an assistant.

(7) The following shall be provided in the surgical service areas:

(a) a control station located to permit visual surveillance of all traffic entering the operating suite;

(b) a drug distribution station; provision shall be made for storage and preparation of medications administered to patients;

(c) scrub facilities shall be provided near the entrance to each operating room which is arranged to minimize incidental splatter on nearby personnel or supply carts;

(d) a soiled workroom which shall contain a clinical sink or equivalent flushing type fixture, a work counter, a sink for hand washing, and waste receptacle(s);

(e) fluid waste disposal facilities which shall be convenient to the general operating rooms; a clinical sink or equivalent equipment in a soiled workroom shall meet this requirement;

(f) a clean workroom or a clean supply room:

(i) a clean workroom is required when clean materials are assembled within the facility prior to use and shall contain: work counter; sink equipped for hand washing; and, space for clean and sterile supplies;

(ii) a clean supply room may be used when the facility does not assemble the material and has procedures for the storage of sterile and clean supplies;

(g) anesthesia storage facilities which meet the standards as outlined in national fire protection association life safety code pamphlet 99; anesthesia may be stored inside or outside as long as the standards are met;

(h) anesthesia workroom for cleaning, testing, and storing anesthesia equipment which shall contain: work counter and sink;

(i) equipment storage room(s) for equipment and supplies used in the surgical area;

(j) staff clothing change area which shall contain: lockers; showers; toilets; lavatories for hand washing; and, space for donning scrub attire;

(k) outpatient surgery change areas for patients to change from street clothing into hospital gowns and to prepare for surgery which shall have the following: waiting room(s); lockers; clothing change or gowning areas; space for administering medications; and, provisions for securing patients' personal effects;

(l) stretcher storage area which shall be convenient for use and out of the direct line of traffic;

(m) for facilities having three (3) or more operating rooms, a lounge and toilet facilities will be provided for the surgical staff;

(n) a nurse's toilet room shall be provided near the recovery room(s);

(o) a janitor's closet exclusively for the surgical suite which shall have: a floor receptor or service sink, and storage space exclusively for house keeping supplies and equipment for the surgical suite;

(p) space for the temporary storage of wheelchairs; and

(q) provisions for convenient access to and use of emergency crash carts at both the surgical and recovery areas.

E. Toilet rooms in surgery and recovery areas for patient use shall be equipped with doors and hardware that permit access from the outside in emergencies. When such rooms have only one opening or are small, the doors shall open outward.

F. Flammable anesthetics shall not be used in ambulatory surgical centers.

G. Ambulatory surgical centers in the same building as another provider such as hospital or clinic must meet the following:

(1) the ambulatory surgical center is not required to be in a building separate from other health care activities (e.g., hospital, clinic, etc.); it must however, be separated physically by at least semi-permanent walls and doors;

(2) the ambulatory surgical center and another entity must not mix functions and operations in a common space during concurrent or overlapping hours of operation;

(3) sharing of a common space at non-overlapping times is acceptable if the ambulatory surgical center is able to fully function without interruption during its scheduled hours of operation;

(4) use of the ambulatory surgical center space by another entity, or host entity if the ambulatory surgical center is on the premises of another health facility, during the ambulatory surgical center's hours of operation is prohibited.

[9/1/56, 7/1/60, 6/27/90; 7.11.2.60 NMAC - Rn & A, 7 NMAC 11.2.60, 02/28/06]

7.11.2.63 ADMINISTRATOR, DIRECTOR OR MANAGER: Each facility must have an administrator/director/manager hired or appointed by the governing body to whom authority has been delegated to manage the daily operation of a facility and implement the policies and procedures adopted by the governing body.

[6/27/90; 7.11.2.63 NMAC - Rn & A, 7 NMAC 11.2.63, 02/28/06]

7.11.2.64 STAFF EVALUATION AND DEVELOPMENT: A facility licensed pursuant to these regulations must have a written plan for the orientation, ongoing staff development, supervision and evaluation of all staff members, including but not limited to the following:

A. facility's emergency and safety procedures;

B. policies and procedures of the facility;

C. quality assurance program; and

D. staff training.

[6/27/90; 7.11.2.64 NMAC - Rn & A, 7 NMAC 11.2.64, 02/28/06]

7.11.2.65 DIRECT SERVICE STAFF: Each staff member who provides direct medical services to patients, such as physicians, dentists, certified registered nurse anesthetists, nurses, physicians assistants, etc., who are required to be licensed, registered or certified by the state of New Mexico must have a current license, registration, or certificate from the state of New Mexico.

[9/1/56, 6/27/90; 7.11.2.65 NMAC - Rn & A, 7 NMAC 11.2.65, 02/28/06]

7.11.2.66 MINIMUM STAFFING REQUIREMENTS:

A. Ambulatory Surgical Centers:

(1) Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the facility.

(2) Surgical staff of qualified physicians who have been granted clinical privileges by the governing body of the facility must perform all surgical procedures. A physician must be on duty whenever there is a patient in the facility.

(3) A certified registered nurse anesthetist or registered nurse must be available for emergency treatment whenever there is a patient in the facility.

B. Diagnostic and Treatment Centers:

(1) A physician must be on duty or on immediate call whenever primary medical services are being provided to patients.

(2) A certified registered nurse anesthetist, registered nurse, licensed practical nurse, nurse practitioner or physician assistant must be on duty whenever patients are in the facility.

(3) Personnel trained in the use of emergency equipment and cardiopulmonary resuscitation must be on duty whenever a patient is in the facility.

C. Limited Diagnostic and Treatment Centers:

(1) A physician must be on call whenever medical services are being given to patients.

(2) A registered nurse, licensed practical nurse, nurse practitioner or physician assistant must be on duty whenever patients are in the facility receiving medical services.

(3) Personnel trained in the use of emergency equipment and cardiopulmonary resuscitation must be on duty whenever a patient is in the facility.

D. Rural Health Clinic:

(1) The physician responsible for the medical direction of the facility must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral.

(2) A physician, nurse practitioner, physician's assistant, registered nurse, or licensed practical nurse must be available to furnish patient care services at all times during the facility's regular hours of operation.

E. Infirmaries:

(1) A physician is on duty or on immediate call whenever primary medical services are being provided to patients.

(2) A registered nurse, licensed practical nurse, nurse practitioner, or physician assistant must be on duty whenever patients are in the facility. This includes nighttime hours when patients are being kept overnight for observation or treatment.

(3) Personnel trained in the use of emergency equipment and cardiopulmonary resuscitation must be on duty whenever a patient is in the facility.

F. New or Innovative Clinic:

(1) Will meet the staffing requirements of Subsection B of 7.11.2.66 NMAC of these regulations.

(2) Additional staffing or modification of staffing may be determined by the licensing authority during the initial phase of the licensing process as outlined in Paragraph 3 of Subsection A of 7.11.2.10 NMAC.

[9/1/56, 7/1/60, 6/27/90; 7.11.2.66 NMAC - Rn & A, 7 NMAC 11.2.66, 02/28/06]

7.11.2.67 EMERGENCY MEDICAL SERVICES:

A. Each facility licensed pursuant to these regulations must maintain a crash cart or emergency medical tray to provide emergency life saving procedures which may be needed in the facility.

B. Crash carts or emergency trays will be supplied with the drugs and biologicals commonly used in life saving procedures such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids. Supplies and equipment for the crash carts or emergency trays will be determined by the medical director of the facility.

C. Each crash cart or

emergency tray will have an (a) equipment and supply list to be used as an inventory guide. Crash carts or emergency trays must be replenished as supplies or equipment are (is) used.

D. Crash carts or emergency trays will be checked on a weekly basis for completeness and a log maintained with date and by whom the check was made.

E. All direct service medical staff must know the location of and be trained in the use of the crash carts or emergency trays.

F. Operating rooms of ambulatory surgical centers must include at least the following:

(1) emergency call system;

(2) oxygen;

(3) mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator;

(4) cardiac defibrillator;

(5) cardiac monitoring equipment;

(6) thoracotomy set;

(7) tracheostomy set;

(8) laryngoscopes and endotracheal tubes;

(9) suction equipment;

(10) emergency drugs and supplies specified by the medical staff.

[9/1/56, 7/1/60, 6/27/90; 7.11.2.67 NMAC - Rn & A, 7 NMAC 11.2.67, 02/28/06]

7.11.2.70 ANESTHESIA SERVICES FOR AMBULATORY SURGICAL CENTERS:

A. A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.

B. Before discharge from the facility each patient must be evaluated by a physician or a certified registered nurse anesthetist for proper anesthesia recovery.

C. All patients will be discharged in the company of a responsible adult, except those exempted by the attending physician.

D. Anesthetics must be administered by only:

(1) a qualified anesthesiologist;

(2) a physician qualified to administer anesthesia, [~~a certified nurse anesthetist,~~] a supervised trainee in an approved educational program or an anesthesia assistant. In those cases where a [~~non-physician~~] trainee or an anesthesia assistant administers the anesthesia, the anesthetist must be under the supervision of the operating physician; anesthesia assistants must have successfully completed four (4) year education program for physician assistants that include two (2) years of specialized academic and clinical training in anesthesia;

(3) a certified registered nurse anesthetist; certified registered nurse anesthetists shall function in an interdependent role as a member of a health care team in which the medical care of the patient is directed by a licensed physician, osteopathic physician, dentist or podiatrist licensed in New Mexico pursuant to Chapter 61, Article 5A, 6, 8 or 10 NMSA 1978; the certified registered nurse anesthetist shall collaborate with the licensed physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care of the patient; as used in this subsection, "collaboration" means the process in which each health care provider contributes his respective expertise; collaboration includes systematic formal planning and evaluation between the health care professionals involved in the collaborative practice arrangement.

[6/27/90; 7.11.2.70 NMAC - Rn & A, 7 NMAC 11.2.70, 02/28/06]

7.11.2.71 PHARMACEUTICAL SERVICES:

A. Drugs and biologicals must be stored, prepared and administered in accordance to acceptable standards of practice and in compliance with the New Mexico state board of pharmacy.

B. Outdated drugs and biologicals must be disposed of in accordance with methods outlined by the New Mexico state board of pharmacy.

C. One individual shall be designated responsibility for pharmaceutical services to include accountability and safeguarding.

D. Keys to the drug room or pharmacy must be made available only to personnel authorized by the individual having responsibility for pharmaceutical services.

E. Adverse reactions to medications must be reported to the physician responsible for the patient and must be documented in the patient's record.

F. Blood and blood products must be administered by only physicians, certified registered nurse anesthetists, registered nurses, nurse practitioners, or physician's assistants.

[9/1/56, 6/27/90; 7.11.2.71 NMAC - Rn & A, 7 NMAC 11.2.71, 02/28/06]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 349 COORDINATED SERVICE CONTRACTORS
PART 2 APPEALS AND GRIEVANCE PROCESS

8.349.2.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.349.2.1 NMAC - N, 3-1-06]

8.349.2.2 SCOPE: The rule applies to the general public.
[8.349.2.2 NMAC - N, 3-1-06]

8.349.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, section 27-2-12 et seq. (Repl. Pamp. 1991).
[8.349.2.3 NMAC - N, 3-1-06]

8.349.2.4 DURATION: Permanent
[8.349.2.4 NMAC - N, 3-1-06]

8.349.2.5 EFFECTIVE DATE: March 1, 2006, unless a later date is cited at the end of a section.
[8.349.2.5 NMAC - N, 3-1-06]

8.349.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.349.2.6 NMAC - N, 3-1-06]

8.349.2.7 DEFINITIONS: [RESERVED]

8.349.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.349.2.8 NMAC - N, 3-1-06]

8.349.2.9 COORDINATED SERVICE CONTRACTORS (CSC): CSCs that manage some services of the medicaid program are responsible for any or all aspects of program management, prior authorization, utilization review, claims processing, and issuance of remittance advices and payments.

A. The CSC shall have a grievance system in place for recipients that include a grievance process related to dissatisfaction and an appeals process related to a CSC's action, including the opportunity to request an HSD fair hearing.

B. A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation, other than a CSC's action, as defined below.

C. An appeal is a request

for review by the CSC of a CSC's action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

D. The recipient, legal guardian of the recipient for a minor or an incapacitated adult, or a representative of the recipient as designated in writing to the CSC, has the right to file a grievance or an appeal of the CSC's action on behalf of the recipient. A provider acting on behalf of the recipient, with the recipient's written consent, may file a grievance and/or an appeal of a CSC's action.

E. In addition to the CSC's grievance and appeal process described above, a recipient, legal guardian of the recipient for a minor or an incapacitated adult, or the representative of the recipient has the right to request a fair hearing on behalf of the recipient with HSD directly as described in 8.352.2 NMAC, *Recipient Hearings*, if a CSC's decision results in termination, modification, suspension, reduction, or denial of services to the recipient or if the recipient believes the CSC has taken an action erroneously. A fair hearing may be requested prior to, concurrent with, subsequent to, or in lieu of a grievance or appeal to the CSC.

[8.349.2.9 NMAC - N, 3-1-06]

8.349.2.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The CSC shall implement written policies and procedures describing how the recipient may submit a request for a grievance or an appeal with the CSC or submit a request for a fair hearing with the human services department (HSD). The policy shall include a description of how the CSC resolves the grievance or appeal.

B. The CSC shall provide to all service providers and subcontractors in the CSC's network a written description of the CSC's grievance and appeal process and how the provider can submit a grievance and/or appeal.

C. The CSC shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

D. The CSC shall name a specific individual(s) designated as the CSC's medicaid recipient grievance coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or an appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action.

E. The CSC shall ensure that the individuals that make the decisions on grievances and/or appeals are not involved in any previous level of review or decision-making. The CSC shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

(1) an appeal of a CSC denial that is based on lack of medical necessity;

(2) a CSC denial that is upheld in an expedited resolution;

(3) a grievance or appeal that involves clinical issues.

F. Upon enrollment, the CSC shall provide recipients, at no cost, with an information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance and/or an appeal, and the resolution process. The recipient information shall also advise recipients of their right to file a request for an administrative hearing with the HSD hearings bureau, upon notification of a CSC action, or concurrent with or following an appeal of the CSC action.

G. The CSC shall ensure that punitive or retaliatory action is not taken against a recipient or a provider that files a grievance and/or an appeal, or a provider that supports a recipients's grievance and/or appeal.

[8.349.2.10 NMAC - N, 3-1-06]

8.349.2.11 GRIEVANCE: A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation.

A. A recipient may file a grievance either orally or in writing with the CSC within ninety (90) calendar days of the date the event causing the dissatisfaction occurred. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, and a provider acting on behalf of the recipient and with the recipient's written consent, have the right to file a grievance on behalf of the recipient.

B. Within five (5) working days of receipt of the grievance, the CSC shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final CSC resolution process for grievances shall be completed within thirty (30)- calendar days of the date the grievance is received by the CSC and shall include a resolution letter to the grievant or the grievant's representative.

D. The CSC may request an extension from HSD up to fourteen (14) calendar days if the grievant requests the extension, or the CSC demonstrates to HSD that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the grievant, the CSC shall give the grievant written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the CSC shall mail a resolution letter to the grievant, legal guardian, representative, and/or provider acting on behalf of the recipient. The resolution letter shall include, but not be limited to, the following:

(1) all information considered in investigating the grievance;

(2) findings and conclusions based on the investigation; and

(3) the disposition of the grievance.

[8.349.2.11 NMAC - N, 3-1-06]

8.349.2.12 APPEALS: An appeal is a request for review by the CSC of a CSC action.

A. An action is defined as:

(1) the denial or limited authorization of a requested service, including the type of level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the CSC to provide services in a timely manner, as defined by HSD; or

(5) the failure of the CSC to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. The CSC shall mail a notice of action to the recipient and/or provider with in 10 days of the date of the action, except for denial of claims that may result in recipient financial liability, which requires immediate notification. The notice shall contain, but not be limited, to the following:

(1) the action CSC has taken or intends to take;

(2) the reasons for the action;

(3) the recipient's or the provider's right to file an appeal of the CSC action through the CSC;

(4) the recipient's right to request an HSD fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and

(7) the recipient's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the recipient may be required to pay the costs of continuing these benefits.

C. A recipient may file an appeal of a CSC action within ninety (90)-calendar days of receiving the CSC's notice of action. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, or a provider acting on behalf of the recipient with the recipient's written consent, have the right to file an appeal of an action on behalf of the recipient.

D. The CSC has thirty (30)-calendar days from the date the initial oral or written appeal is received by the CSC to resolve the appeal.

E. The CSC shall have a process in place that ensures that an oral or written inquiry from a recipient seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). The CSC shall use its best efforts to assist recipients as needed with the written appeal.

F. Within five (5) working days of receipt of the appeal, the CSC shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The CSC shall confirm in writing receipt of oral appeals, unless the recipient or the provider requests an expedited resolution.

G. The CSC may extend the thirty (30) days time frame by fourteen (14) calendar days if the recipient requests the extension, or the CSC demonstrates to HSD that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the recipient, the CSC shall give the recipient written notice of the extension and the reason for the extension within two (2) working days of the decision to extend the time frame.

H. The CSC shall provide the recipient and/or the recipient's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

I. The CSC shall provide the recipient and/or the representative the opportunity, before and during the appeals process, to examine recipient's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The CSC shall include as parties to the appeal the recipient and his or her representative, or the legal representative of a deceased recipient's estate.

J. For all appeals, the CSC shall provide written notice within the thirty (30)-calendar-day timeframe for resolution to the grievant, legal guardian, representative, and/or provider acting on behalf of the recipient.

(1) The written notice of the appeal resolution shall include, but not be limited to, the following information:

(a) the results of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the recipient shall include, but not be limited to, the following information:

(a) the right to request an HSD fair hearing and how to do so:

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the recipient may be held liable for the cost of continuing benefits if the hearing decision upholds the CSC's action.

K. The CSC may continue benefits while the appeal and/or the HSD fair hearing process is pending.

(1) The CSC shall continue the recipient's benefits if all of the following are met:

(a) the recipient or the provider files a timely appeal of the CSC action within ten (10) days of the date on the notice of action from the CSC);

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment:

(c) the services are ordered by an authorized provider;

(d) the recipient requests extension of benefits.

(2) The CSC shall provide benefits until one of the following occurs:

(a) the recipient withdraws the appeal;

(b) ten (10) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the recipient and the recipient has taken no further action;

(c) HSD issues a hearing decision adverse to the recipient;

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the recipient, that is, the CSC's action is upheld, the CSC may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

(4) If the CSC or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending the CSC shall authorize or provide the disputed services promptly and as expeditiously as the recipient's health condition requires.

(5) If the CSC or HSD reverses a decision to deny, limit or delay services and the recipient received the disputed services while the appeal was pending, the CSC shall pay for these services.

[8.349.2.12 NMAC - N, 3-1-06]

8.349.2.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the CSC of a CSC action.

A. The CSC shall establish and maintain an expedited review process for appeals when the CSC determines that allowing the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the recipient;

(2) a provider's support of the recipient's request;

(3) a provider's request on behalf of the recipient; or

(4) the CSC's independent determination.

B. The CSC shall ensure that the expedited review process is convenient and efficient for the recipient.

C. The CSC shall resolve the appeal within three (3) working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in 8.349.2.13 NMAC.

D. The CSC may extend the time frame by up to fourteen (14) calendar days if the recipient requests the extension, or the CSC demonstrates to HSD that there is need for additional information and the extension is in the recipient's interest. For an extension not requested by the recipient, the CSC shall give the recipient written notice of the reason for the delay.

E. The CSC shall ensure that punitive action is not taken against a recipient or a provider who requests an expedited resolution or supports a recipient's expedited appeal.

F. The CSC shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the recipient or provider on behalf of the recipient.

G. The CSC shall inform the recipient of the limited time available to present evidence and allegations in fact or law.

H. If the CSC denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the thirty (30)-day timeframe for standard resolu-

tion, in which the thirty (30)-day period begins on the date the CSC received the original request for appeal;

(2) make reasonable efforts to give the recipient prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days; and

(3) inform the grievant in the written notice of the right to file an appeal and/or request an HSD fair hearing if the recipient is dissatisfied with the CSC's decision to deny an expedited resolution.

I. The CSC shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.349.2.13 NMAC - N, 3-1-06]

8.349.2.14 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the CSC shall, within seventy-two (72) hours of receipt of the request for service, automatically file an appeal on behalf of the recipient, use its best effort, to give the recipient oral notice of the decision on the automatic appeal and to resolve the appeal.

[8.349.2.14 NMAC - N, 3-1-06]

8.349.2.15 OTHER RELATED COORDINATED SERVICE CONTRACTOR (CSC) PROCESSES:

A. Information about grievance system to providers and subcontractors: The CSC shall provide information specified in 42 CFR438.10(g) (1) about the grievance system to all providers and subcontractors at the time that they enter into a contract.

B. Grievance and/or appeal files:

(1) All grievance and/or appeal files shall be maintained in a secure and designated area and accessible to HSD, upon request, for review. Grievance and/or appeal files shall be retained for six (6) years following the final decision by the CSC, HSD, and administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The CSC shall have procedures for assuring that files contain sufficient information to identify the grievance and/or appeal, the date it was received, the nature of the grievance and/or appeal, notice to the recipient of receipt of the grievance and/or appeal, all correspondence between the CSC and the recipient, the date the grievance and/or appeal is resolved, the resolution, the notices of final decision to the recipient, and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the grievant, legal guardian representative, and/or provider acting on behalf of the recipient if requested.

[8.349.2.15 NMAC - N, 3-1-06]

8.349.2.16 COORDINATED SERVICE CONTRACTOR (CSC) PROVIDER GRIEVANCE PROCESS: The CSC shall establish and maintain written policies and procedures for the filing of provider grievances. A provider shall have the right to file a grievance with the CSC regarding utilization management decisions and/or provider payment issues. Grievances shall be resolved within thirty (30) calendar days. A provider may not file a grievance on behalf of a recipient without written designation by the recipient as the recipient's representative. See 8.349.2.14 NMAC for special rules for certain expedited service authorizations.

[8.349.2.16 NMAC - N, 3-1-06]

History of 8.349.2 NMAC: [RESERVED]

NEW MEXICO
HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Explanatory Paragraph: This is an amendment to 8.200.430 NMAC, Section 16, which will be effective on March 1, 2006. The Medical Assistance Division amended the Subsections to exclude the employer portion of the premium from the cost-sharing maximum calculation. In addition, various minor modifications have been made to delete procedural information.

8.200.430.16 RECIPIENT FINANCIAL RESPONSIBILITIES: Providers who participate in medicaid agree to accept the amount paid as payment in full, see 42 CRF 447.15, with the exception of co-payment amounts required in certain medicaid categories. Other than the co-payments, a provider cannot bill a recipient for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error or failure of multiple providers to communicate eligibility information. Native Americans are exempt from co-payment requirements.

G. **Co-payment responsibility for state coverage insurance (SCI) recipients:** It is the recipient's responsibility to pay the co-payment to the provider. Adults eligible for category 062 with family income from 0-200% of federal poverty limit will have co-payment responsibility as follows:

[continued on page 236]

Service	Co-pay at 0% - 100% FPL- 062[~~A~~]	Co-pay at 101% - 150% FPL - 062[~~B~~]	Co-pay at 151% - 200% FPL-062[~~C~~]
Physician/provider visits (no co -pay for preventive services-see below)	$0	$5	$7
Pre/post natal care	$0	$0	$0
Preventive services	$0	$0	$0
Hospital inpatient medical/surgical	$0/day	$25/day	$30/day
Hospital inpatient maternity	$0/day	$25/day	$30/day
Hospital outpatient surgery/procedures	$0	$5	$7
Home health	$0	$5	$7
PT, OT & SLP	$0	$5	$7
Diagnostics (excluding routine lab and x -ray)	$0 (included in office visit)	$0 (included in office visit)	$0 (included in office visit)
DME/supplies	$0	$5	$7
[~~Mental health/substance abuse outpatient~~	~~$0~~	~~$5~~	~~$7~~
~~Mental health/substance abuse inpatient~~	~~$0~~	~~$25~~	~~$30~~
~~Substance abuse intensive outpatient~~	~~$0~~	~~$5~~	~~$7~~]
Emergency services	$0	$15 per visit, waived if admitted to a hospital within 24 hours	$20 per visit, waived if admitted to a hospital within 24 hours
Urgent care	$0	$5	$7
Prescription drugs: generic name brand	$3 per prescription	$3 per prescription	$3 per prescription
Behavioral health and substance abuse: outpatient office visit and outpatient substance abuse treatment inpatient behavioral health and inpatient detox	$0 $0	$5 $25	$7 $30
Limits on out -of-pocket expenses	Out of pocket charges for all participants will be limited to 5% of [~~maximum gross~~] countable family income per benefit year. Pharmacy out -of-pocket charges for all participants will be limited to $12 per month.		

I. [~~**Co-payment**~~] **Cost-sharing maximum for SCI recipients:** It is the responsibility of the client to track and total the co-payments and the employee portion of the premiums paid. The employer portion of the premium is not counted toward the cost-sharing maximum and must be paid by (or on behalf of) the individual enrollee each month regardless of income category and/or cost-sharing maximum status. Once the yearly maximum amount for SCI recipients has been paid by the individual via co-payments and the employee portion of the premiums on covered services, the recipient must notify the managed care organization (MCO) in which he or she is enrolled. [~~Verification must be provided~~] It is the client's responsibility to notify the MCO and provide verification to the MCO that the cost-sharing maximum for SCI has been paid. The first month that cost-sharing will no longer be required by the SCI recipient is the month following the month in which it has been verified by the MCO that the maximum amount has been met. If the determination is made after the twenty-fourth (24th) of the month, the change is made effective the second month after verification. No retroactive eligibility for the "met cost-sharing maximum" criteria is allowed. Subsequent to establishing that the cost-sharing maximum amount has been met, the SCI recipient is not responsible for payment of co-payments and employee portion of the premiums for the remainder of that benefit year. Co-payment maximum amounts for SCI recipients are calculated at initial determination and re-determination of eligibility by ISD at 5% of the annual countable income. The co-payment maximum amount calculated at the re-determination is effective for the following benefit year. See also 8.262.600.9 NMAC.

[2-1-95, 3-1-99, 7-1-00; 8.200.430.16 NMAC - Rn, 8 NMAC 4.MAD.437 & A, 1-1-01; A, 1-1-02; A, 6-1-04; A, 6-15-04; A, 7-1-05; A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

Explanatory Paragraph: This is an amendment to Subsection F of Section 7 of 8.262.400 NMAC, which will be effective on March 1, 2006. The Medical Assistance Division amended the definition of a category. In addition, various minor modifications have been made to delete procedural information.

8.262.400.7 DEFINITIONS:

F. **Category:** A designation of the automated eligibility system. [~~SCI has one designated category 062 and three subcategories (062-A, 062-B, 062-C) that are assigned to an individual based on his or her income grouping.~~] The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, subject to change by request from the recipient.

DD. **Premium- employee-** A specific monthly payment payable to the MCO calculated by the department based on a subcategory of eligibility representing an income grouping. [~~062A 0-100% FPL, 062B 101-150% FPL, 062C 151-200% FPL~~] 062 0-100% FPL, 062 101-150% FPL, 062 151-200% FPL.

GG. **Shoebox method:** The method under which an SCI member is responsible for tracking, and submission of a request for verification of total expenditures for himself, based on SCI employee premiums and copayments for purposes of establishing that the cost-sharing maximum amount has been met.

[8.262.400.7 NMAC - N, 7-1-05; A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.262.500 NMAC, Section 9, which will be effective on March 1, 2006. The Medical Assistance Division amended the SCI category designation.

8.262.500.9 ESTABLISHING NEED - GENERAL REQUIREMENTS: Methodology for establishing financial eligibility for state coverage insurance (SCI) uses New Mexico works cash assistance definitions of income, rules for income availability, and exempt income.

A. **Income test:** In order to be eligible for SCI, countable income (after applicable exemptions and disregards) must meet the SCI income limit for the appropriate family size. The SCI income standards are based on 200% of federal poverty levels (FPLs). SCI uses New Mexico works income definitions and methodologies. (Also see 8.102.520.8 NMAC through 8.102.520.15 NMAC). SCI eligibility and cost-sharing levels will be determined based on one income test using countable income (after applicable exemptions and disregards).

B. **Payment standard increments:** Payment standard increments for nonsubsidized housing living arrangements and clothing allowance do not affect the SCI eligibility process, i.e., the eligibility limits for income are not increased by the amount of the nonsubsidized housing or clothing allowance payment increments.

C. **Excess hours work deduction:** This deduction is not applicable to SCI.

D. **SCI category designation:** SCI eligibles will be assigned one category of eligibility (062) [~~and one of three subcategories of SCI eligibility 062A 0-100% FPL; 062B 101-150% FPL; and 062C 151-200% FPL that are based on income level as determined at the time of application~~]. The income grouping (subcategory) will control the employee premium and copayment amounts.

[8.262.500.9 NMAC - N, 7-1-05; A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.262.600 NMAC, Sections 9 and 10, which will be effective on March 1, 2006. The Medical Assistance Division amended the sections to exclude the employer portion of the premium from the cost-sharing maximum calculation.

8.262.600.9 BENEFIT DESCRIPTION: The benefit package is described in 8.306.7. NMAC, *Benefit Package*, SCI benefits are administered by contracted managed care organizations. There is no fee-for-service coverage under the SCI program.

A. The level of cost-sharing (i.e., the premium and co-payment amounts as well as the cost-sharing maximum amounts) required in the SCI program is contingent upon the income grouping associated with the applicant's countable income at the point of the application disposition. See also 8.262.500.9 NMAC.

B. The cost-sharing maximum is an amount calculated for the benefit year that represents an amount equal to 5% of the [~~individual's~~] enrollee countable income at the time of the application disposition. It is the responsibility of each SCI-covered individual to track and total the amounts paid for the SCI employee portion of the premiums and SCI co-payments on SCI-covered services in a benefit year. Once the cost-sharing maximum amount has been paid by an SCI-covered individual, the individual must notify the MCO and provide verification of the paid amounts. Once the paid amounts have been verified as paid, the individual will not owe further employee premium or co-payment amounts for the remainder of that benefit year. The first month that cost sharing is not required by the SCI-covered individual is the month following the month in which it has been verified by the MCO that the cost-sharing maximum amount has been met. If the determination is made after the twenty-fourth (24^{th}) of the month, the change is made effective the second month after the verification. No retroactive eligibility for the "met cost-sharing maximum" amount is allowed. The employer portion of the premium is not counted toward the cost-sharing maximum and must be paid by (or on behalf of) the individual enrollee each month regardless of income category and/or cost-sharing maximum status.

C. Employer share payable by individual: An individual member (one who is enrolled outside of an employer group) is responsible for payment of the premium share for the employee as determined by federal poverty level and the employer premium. [~~These premiums will be counted as part of the calculation for co-payments and premiums to determine the cost-sharing maximum.~~] The employer portion of the premiums will not be counted toward the cost-sharing maximum.

[8.262.600.9 NMAC - N, 7-1-05; A, 3-1-06]

8.262.600.10 BENEFIT DETERMINATION: Benefits will begin when it is established that an individual has met all eligibility and enrollment criteria for a given month. Benefits will be issued only via the managed care contractor selected by the individual; there is no fee-for-service coverage. A member of an employer group who has met the cost sharing maximum amount will receive coverage without copayments or premiums for the employee share, for the remainder of the benefit year. The employer will retain responsibility for the employer portion of the premium for the remainder of the benefit year. An individual who is not part of an employer group and has met the cost-sharing maximum amounts will receive coverage without payment of premiums for [~~both the employer and~~] the employee premium shares and co-payments for the remainder of that benefit year. The employer portion of the premium is not counted in the cost-sharing maximum calculations and must still be paid each month. If another entity has made cost-sharing payment on behalf of an individual, those "third party" paid amounts will not be counted toward the cost-sharing maximum.

[8.262.600.10 NMAC - N, 7-1-05; A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Explanatory Paragraph: This is an amendment to 8.306.1 NMAC, Section 7, which will be effective on March 1, 2006. The Medical Assistance Division amended the definitions for a "category" and "client". In addition, various minor modifications have been made to delete procedural information.

8.306.1.7 DEFINITIONS: The state of New Mexico is committed to reducing the number of uninsured working New Mexico residents and improving the number of small employers offering health benefit plans by implementation of a basic health coverage health insurance benefit provided by contracted managed care organization with cost sharing by members, employers and the state and federal governments. This section contains the glossary for the New Mexico state coverage insurance policy. The following definitions apply to terms used in this chapter.

C. Definitions beginning with letter "C":

(4) **Category:** A designation of the automated eligibility system. SCI has one designated category (062) and three [~~subcategories (062-A, 062-B, 062-C)~~] income groupings that are assigned to an individual based on their income grouping. The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, subject to change by request from the recipient.

(6) **Client:** An individual who has applied for and been determined eligible for SCI. A [~~"member"~~] "client" may also be referred to as a "member," "customer," or "consumer", or "program participant".
[8.306.1.7 NMAC - N, 7-1-05; A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Explanatory Paragraph: This is an amendment to 8.306.5 NMAC, Sections 9 and 11, which will be effective on March 1, 2006. The Medical Assistance Division amended the enrollment requirements in section 9 and repealed section 11.

8.306.5.9 ENROLLMENT PROCESS:

A. **Enrollment requirements:** The managed care organization (MCO) shall provide an open enrollment period during which the MCO [~~shall accept eligible individuals~~] will enroll individuals in accordance with accepted MCO practice in the order in which they apply, [~~without restriction, unless authorized by the CMS regional administrator,~~] up to the limits contained in the contract. The MCO shall not discriminate on the basis of health status or a need for health care services. The MCO shall not discriminate against individuals eligible to enroll on the basis of disability, race, color, national origin, or sexual orientation. The MCO shall not use any policy or practice that has the effect of discriminating on the basis of disability, race, color, national origin, or sexual orientation. All enrollments shall be voluntary and based on member or employer choice.
[8.306.5.9 NMAC - N, 7-1-05; A, 3-1-06]

8.306.5.11 [~~MEMBER SELECTION:~~ ~~A new SCI member selects an MCO prior to applying for eligibility from HSD. Once an MCO is selected, the employer/employee or individual is instructed by the MCO or designee to download eligibility application forms from the SCI website or obtain an application form from a designated outreach center. The application together with required verification documents will be sent to an ISD office. The ISD office shall process the application within the 45 day time frame specified by ISD regulation and generate a letter of eligibility to the member or a letter of denial of eligibility along with the appropriate fair hearing information. The eligibility determination will only be sent to the individual/employee. An employer shall obtain the letter of eligibility from his employee to complete the employer group application process.~~] [RESERVED]
[8.306.5.11 NMAC - N, 7-1-05; Repealed, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.306.11 NMAC, Section 9, which will be effective on March 1, 2006. The Medical Assistance Division amended the Subsection D to exclude the employer portion of the premium from the cost-sharing maximum calculation.

8.306.11.9 REIMBURSEMENT:

A. MCO and HSD shall comply with 8.305.11.9 NMAC, *Reimbursement for Managed Care* for the SCI program.

B. **Payment of premiums:** In addition to capitation payments from HSD, the MCO shall receive premium payments as specified by HSD. Premiums will be paid as follows:

(1) **employer premium** amount determined by department; and

(2) **employee or individual premium** determined by department based on the federal poverty limits as follows: 0-100% per month, 101-150% per month, 151-200% per month,

C. **Premium timeframes:** Initial premiums are due to the MCO immediately upon enrollment and prior to the 1st day of the month before coverage begins. An employer group or individual member can only receive coverage when the premium has been paid. Capitation payments will not be paid unless verification of premium payment through the roster is received. If payment is not current within that timeframe, the employer group or individual member will not be covered for the next month and will not be able to enroll in an SCI MCO for a period of twelve months for an employer group or six months for an individual member.

D. **Responsibility for premium payment:** For members in an employer group, the employer shall be responsible for ensuring payment of the employer and employee share (if any) of premiums. For individuals who are not affiliated with an employer group, the individual or an entity paying on behalf of an individual shall be responsible for payment of both the employer and individual premium amount (if any). If a member who is part of an employer group has met the cost-sharing maximum, as verified by the MCO[~~.~~], HSD shall be responsible for payment of the member's[~~:~~] but not the employer's share of premiums. For individual members not in an employer group who have met the cost-sharing maximum, HSD shall be responsible for [~~both~~] the member's [~~and the employer's share of premiums.~~] share of the premium. The member will continue to be responsible for the employer's share of the premium.
[8.306.11.9 NMAC - N, 7-1-05; A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.352.2 NMAC, Section 7, which will be effective on March 1, 2006. The Medical Assistance Division amended the definition of SCI in Subsection K.

8.352.2.7 DEFINITIONS:

A. "Action" means a termination, modification, reduction, or suspension of a covered service.

B. "Contractor" means a managed care organization (MCO), or HSD's utilization review contractor.

C. "Date of action" means the intended date on which a termination, modification, reduction, or suspension becomes effective.

D. "Denial" means the decision not to authorize a requested service.

E. "Hearing" or "administrative hearing" means an evidentiary hearing that is conducted so that evidence may be presented.

F. "HSD" means the human services department.

G. "MAD" means the medicaid assistance division.

H. "Notice" means a written statement that includes what action is being taken, the reasons for the intended action, the specific regulation that requires the action, and an explanation of the recipient's right to request a hearing, along with an explanation of the circumstances under which the service may be continued if a hearing is requested.

I. "Parties to the hearing" are the human services department (HSD) and the recipient. If the hearing issue is an MCO action, the parties are HSD, the recipient, and the MCO.

J. "Request for hearing" means a clear expression by a recipient or an authorized representative that the recipient wants the opportunity to present his or her case to a reviewing authority.

K. "State coverage insurance" SCI- health insurance flexibility and accountability waiver program for coverage of uninsured working adults.

L. "Utilization review contractor" is a contractor with the New Mexico medicaid program responsible for medical level of care reviews and medical necessity reviews for fee-for-service (not MCO) services.
[11-1-96, 1-1-00; 8.352.2.7 NMAC - Rn, 8

NMAC 4.MAD.970.1 & A, 7-1-01; A, 7-1-05; A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.301.2 NMAC, Section 9 that will be effective on March 1, 2006. The Medical Assistance Division amended the section by adding language to show that some services may be managed by Coordinated Service Contractors. This rule was also renumbered and reformatted from 8 NMAC 4.MAD.601 to comply with NMAC requirements.

8.301.2.9 GENERAL PROGRAM DESCRIPTION:

A. The New Mexico medicaid program (medicaid) pays for medically necessary health care services furnished by medical providers who participate in medicaid. See 42 CFR 440.210; Section 27-2-16 NMSA 1978 (Repl. Pamp. 1991). Medicaid covers a range of medical services, including [~~traditional~~] acute care services, transportation, physician services, home health care, durable medical equipment and medical supplies, tot to teen healthchecks, pharmacy services, and institutional and community-based long-term care services.

B. Medicaid covers services which are medically necessary for the diagnosis and/or treatment of illnesses, injuries or conditions of recipients, as determined by the medical assistance division (MAD). All services [~~are~~] must be furnished within the limits of medicaid benefits, within the scope and practice of the provider as defined by state law and in accordance with applicable federal, state, and local laws and regulations. Any claim submitted to MAD for reimbursement is subject to review by MAD or its designee to verify the medical necessity of the service.

[2-1-95; 8.301.2.9 NMAC - Rn, 8 NMAC 4.MAD.601 & A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.301.3 NMAC, Sections 5, 9 through 13, 15, 16, 18, 21, 23, 24, 25, and 27 through 31, that will be effective on March 1, 2006. The Medical Assistance Division amended some sections in order to move citations to the proper sections and clarify citations referring to 20 and under vs. 21 and older. This rule was also renumbered and reformatted from 8 NMAC 4.MAD.602 to comply with NMAC requirements.

8.301.3.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.

[1-1-95, 2-1-95; 8.301.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5 & A, 3-1-06]

8.301.3.9 GENERAL NON-COVERED SERVICES: [~~Certain procedures, services, or miscellaneous items are not covered by medicaid.~~] Medicaid does not cover certain procedures, services, or miscellaneous items. This section contains a general description of the types of services [~~which~~] that medicaid does not cover. [~~See~~] Also see specific provider or service sections for [~~specific~~] additional information on service coverage and limitations.

[2-1-95; 8.301.3.9 NMAC - Rn, 8 NMAC 4.MAD.602 & A, 3-1-06]

8.301.3.10 APPOINTMENT, INTEREST AND CARRYING CHARGES: Medicaid does not cover penalties for broken or missed appointments, costs of waiting time, and interest or carrying charges on accounts. Providers may not bill medicaid or medicaid recipients for the penalties associated with missed or broken appointments, with the exception of [~~category 032 SCHIP~~] recipients eligibility categories SCHIP or WDI recipients who may be charged up to $5 for a missed appointment. [~~Based on standard provider practice, a recipient may be billed for cancellation of an appointment without adequate notice.~~]

[2-1-95; 3-1-99; 8.301.3.10 NMAC - Rn, 8 NMAC 4.MAD.602.1 & A, 3-1-06]

8.301.3.11 CONTRACT SERVICES: Services furnished by contractors, organizations, or individuals [~~which~~] who are not the billing provider must meet specific criteria for coverage by medicaid. See 8.302.2 NMAC, *Billing for Medicaid Services*.

[2-1-95; 8.301.3.11 NMAC - Rn, 8 NMAC 4.MAD.602.2 & A, 3-1-06]

8.301.3.12 COSMETIC SERVICES AND SURGERIES: Medicaid does not cover cosmetic items or services [~~which~~] that are prescribed or used for aesthetic purposes [~~only~~]. This includes items[~~, such as retin-A~~] for aging skin, [~~Rogain~~] for hair loss, and personal care items, such as non-prescription lotions, shampoos, soaps or sunscreens. Medicaid does not cover cosmetic surgeries performed for aesthetic purposes [~~only~~]. "Cosmetic surgery" is defined as procedures performed to improve the appearance of physical features. The procedures may or may not improve the functional ability of the area of concern. Medicaid covers only surgeries that meet specific criteria and are approved as medically necessary reconstructive surgeries.

[2-1-95; 8.301.3.12 NMAC - Rn, 8 NMAC 4.MAD.602.3 & A, 3-1-06]

8.301.3.13 DENTAL SERVICES: Medicaid does not cover dental services [~~which~~] that are performed for aesthetic or cosmetic purposes [~~only. Medicaid does not cover~~] Medicaid covers orthodontic services only for recipients [~~over twenty-one (21) years of age or for recipients under twenty-one (21) years of age who do not meet specific criteria.~~] less than twenty-one (21) years of age and only when specific criteria are met. See 8.310.7 NMAC, *Dental Services*.

[2-1-95; 8.301.3.13 NMAC - Rn, 8 NMAC 4.MAD.602.4 & A, 3-1-06]

8.301.3.15 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES: Medicaid does not cover durable medical equipment or medical supplies that meet any of the following criteria:

A. items [~~which~~] that do not primarily [~~and customarily~~] serve a therapeutic purpose and/or are generally used for comfort or convenience purposes;

B. environment-control equipment [~~which~~] that is not primarily medical in nature, such as air cleaners;

C. institutional equipment [~~which~~] that is not appropriate for home use, such as air-fluidized bead beds;

D. items [~~which~~] that are not generally accepted by the medical profession as being therapeutically effective or are determined by medicare regulations to be ineffective or unnecessary;

E. items [~~which~~] that are hygienic in nature, such as home type bed baths;

F. hospital or physician diagnostic items, such as [~~electrocardiocorder~~] cardiovert;

G. instruments or devices manufactured for use by physicians, such as esophageal dilator;

H. items not essential to the administration of moist heat therapy, such as hydrocollator heating units;

I. exercise equipment not primarily medical in nature;

J. items [~~which~~] that produce no demonstrable therapeutic effect, such as myoflex muscle stimulators;

K. support exercise equipment primarily for institutional use, such as parallel bars [~~if, in the home setting, other devices satisfy the recipient's need, such as walkers~~];

L. items [~~which~~] that are not reasonable or necessary for monitoring the pulse of homebound recipients with or without cardiac pacemakers, such as pulse

tachometers;

M. items [~~which~~] that are used to improve appearance or for comfort purposes, such as sauna baths or wigs; and

N. items [~~which~~] that are precautionary in nature, such as spare tanks of oxygen in addition to portable backup systems.

O. see 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

[2-1-95; 3-1-99; 8.301.3.15 NMAC - Rn, 8 NMAC 4.MAD.602.6 & A, 3-1-06]

8.301.3.16 EDUCATIONAL OR VOCATIONAL SERVICES: Medicaid does not cover literature, booklets, and other educational materials. Dietary counseling is covered only for recipients [~~under~~] less than twenty-one (21) years of age, as part of the early and periodic screening, diagnosis and treatment (EPSDT) program and for pregnant women. Medicaid does not cover formal educational or vocational training services, unless those services are included as active treatment services for recipients in intermediate care facilities for the mentally retarded or for recipients [~~under~~] less than twenty-one (21) years of age receiving inpatient psychiatric services. See 42 CFR 441.13(b). "Formal educational services" relate to training in traditional academic subjects. Vocational training services relate to organized programs directly related to the preparation of recipients for paid or unpaid employment.

[2-1-95; 8.301.3.16 NMAC - Rn, 8 NMAC 4.MAD.602.7 & A, 3-1-06]

8.301.3.18 FOOT CARE: [~~Medicaid does not cover the following foot care services:~~

~~A. Routine care of the foot, including cutting or removal of corns or calluses, nail trimming and other services performed in the absence of localized or systemic illness, injury or symptoms involving the foot; Routine foot care procedures may be covered if performed as a necessary and integral part of an otherwise covered service, such as the diagnosis and treatment of diabetic ulcers, wounds or infection.~~

~~B. Services directed toward the care or correction of a flat foot condition. "Flat foot" is defined as a condition in which one or both of the arches in the foot have flattened out;~~

~~C. Orthopedic shoes and other supportive devices for feet; and~~

~~(1) This exclusion does not apply to a shoe that is an integral part of a leg brace.~~

~~(2) Reimbursement for the device is based on the cost of the entire leg brace and not on the isolated cost of the shoe or support device.~~

~~D. Surgical and non-surgical treatments undertaken for the sole purpose of correcting an isolated subluxated structure in the foot. "Subluxation of the foot" is defined as a partial dislocation or displacement of joint surfaces, tendons, ligaments, or muscles of the foot.~~] Medicaid does not cover certain routine foot care services. For detailed description of covered and non-covered services, see 8.310.11 NMAC, *Podiatry Services*.

[2-1-95; 8.301.3.18 NMAC - Rn, 8 NMAC 4.MAD.602.9 & A, 3-1-06]

8.301.3.21 PHARMACY SERVICES: Medicaid does not cover methadone used in drug treatment programs. Medicaid does not cover drug items [~~which~~] that are classified as ineffective by the food and drug administration (FDA) and antitubercular drug items [~~which~~] that are available from the public health department. In addition, medicaid does not cover personal care items or pharmacy items used for cosmetic purposes only. See also 8.324.4 NMAC, *Pharmacy Services*.

[2-1-95; 8.301.3.21 NMAC - Rn, 8 NMAC 4.MAD.602.12 & A, 3-1-06]

8.301.3.23 PREGNANCY TERMINATION PROCEDURES: Medicaid does not cover elective pregnancy termination procedures. For detailed description of covered and noncovered services, see 8.325.7 NMAC, *Pregnancy Termination Procedures*.

[2-1-95; 8.301.3.23 NMAC - Rn, 8 NMAC 4.MAD.602.14 & A, 3-1-06]

8.301.3.24 PREPARATIONS DISPENSED FOR HOME USE: Medicaid does not cover oral, topical, otic, or ophthalmic preparations dispensed to recipients by physicians, clinics, nurse practitioners, physician assistants, or optometrists for home use or self administration.

[2-1-95; 8.301.3.24 NMAC - Rn, 8 NMAC 4.MAD.602.15 & A, 3-1-06]

8.301.3.25 PROVIDER INELIGIBILITY: Providers must be eligible for participation in medicaid at the time services are furnished. Medicaid does not cover services performed during a time period when the providers or facilities did not meet required licensing or certification requirements, or when the providers' participation was not approved by MAD. [~~Medicaid does not cover services furnished to primary care network (PCN) members or to recipients who are placed in medical management by a provider who is not the member's PCN provider, the "designated provider" or a secondary provider, without a referral from the PCN provider or the medical management "designated provider".~~]

[2-1-95; 8.301.3.25 NMAC - Rn, 8 NMAC 4.MAD.602.16 & A, 3-1-06]

8.301.3.27 [~~REQUIRED SERVICES~~] NON-COVERED SERVICES: Medicaid does not cover [~~visits to pick up prescriptions,~~] broken appointments, or telephone consultations. [~~While medicaid will not reimburse providers for missed or broken appointments, a category 032 SCHIP recipient may be billed $5 for a missed appointment. Based on standard provider practice, a recipient may be billed for cancellation of an appointment without adequate notice.~~] Transportation to pharmacies is not a benefit of the program when other options are available.

[2-1-95; 3-1-99; 8.301.3.27 NMAC - Rn, 8 NMAC 4.MAD.602.18 & A, 3-1-06]

8.301.3.28 ROUTINE PHYSICAL EXAMINATIONS: Medicaid [~~does not cover~~] covers routine physical examinations for non-institutionalized recipients [~~over~~] less than twenty-one (21) years of age. Medicaid covers routine examinations for recipients residing in nursing facilities or intermediate care facilities for the mentally retarded. Physical examinations, screenings, and treatment are available to recipients [~~under~~] less than twenty-one (21) years of age through the tot to teen healthcheck screen, New Mexico's EPSDT screening program.

[2-1-95; 8.301.3.28 NMAC - Rn, 8 NMAC 4.MAD.602.19 & A, 3-1-06]

8.301.3.29 SCREENING SERVICES: Medicaid does not cover screening services [~~which~~] that are not used to make a diagnosis, such as chromosome screening, hypertension screening, diabetic screening, general health panels, executive profiles, paternity testing, or premarital screens. Medicaid covers screening services for children [~~under~~] less than twenty-one (21) years of age through the tot to teen healthcheck program. Medicaid covers screening services ordered by providers for cancer detection, such as pap smears and mammograms.

[2-1-95; 8.301.3.29 NMAC - Rn, 8 NMAC 4.MAD.602.20 & A, 3-1-06]

8.301.3.30 SERVICES NOT COVERED BY MEDICARE: Medicaid does not cover services, procedures, or devices [~~which~~] that are not covered by medicare due to their determination that the service, procedure or device is ineffective or of questionable efficacy.

[2-1-95; 8.301.3.30 NMAC - Rn, 8 NMAC 4.MAD.602.21 & A, 3-1-06]

8.301.3.31 SERVICE REQUIREMENTS NOT SATISFIED: Medicaid does not reimburse for services or

procedures for which any required prior [~~approval~~] authorization, documentation, acknowledgements, or filing limits have not been [~~furnished~~] met by providers. See 8.302.1 NMAC, *General Provider Policies*].

[2-1-95; 8.301.3.31 NMAC - Rn, 8 NMAC 4.MAD.602.22 & A, 3-1-06]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.325.4 NMAC, Sections 5, 10 through 15, & 17 that will be effective on March 1, 2006. The Medical Assistance Division amended the section to allow recipients that are already receiving other services to elect hospice services. This rule was also renumbered and reformatted from 8 NMAC 4.MAD.763 to comply with NMAC requirements.

8.325.4.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.

[2/1/95; 8.325.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5 & A, 3-1-06]

8.325.4.10 E L I G I B L E PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation [~~agreements~~] by the New Mexico medical assistance division (MAD), hospice agencies meeting the following conditions are eligible to be reimbursed for providing hospice care services:

(1) meet the conditions for participation: see 42 CFR [~~Section 418 Subpart C~~] 418.50 et. seq.;

(2) licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH); and

(3) are a public or private nonprofit or for profit agency or a subdivision of either, primarily engaged in providing care to terminally ill individuals.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/95; 8.325.4.10 NMAC - Rn, 8 NMAC 4.MAD.763.1 & A, 3-1-06]

8.325.4.11 P R O V I D E R RESPONSIBILITIES: [~~Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements.~~] Providers who furnish services to medicaid recipients must comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the State Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and it appendices, as updated. See, 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. [~~Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients.~~] Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 431.107(B)]. Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.325.4.11 NMAC - Rn, 8 NMAC 4.MAD.763.2 & A, 3-1-06]

8.325.4.12 E L I G I B L E RECIPIENTS: [~~To be eligible for hospice care, a recipient must be certified by a physician as having a terminal illness.~~] To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. Recipients must elect to receive hospice care for the duration of the election period.

A. **Certification of terminal illness:** The hospice must obtain a written certification statement signed by the hospice medical director, physician member of the hospice interdisciplinary team or recipient's attending physician that the recipient is terminally ill. [~~The written certification must be signed by the physician within seven (7) calendar days of the date hospice services are initiated. Certification statements must include information which verifies that, based on the recipient's medical prognosis, life expectancy is six (6) months or less if the terminal illness runs its normal course.~~] The physician must sign the written certification within seven (7) calendar days of the date services are initiated. Certification statements must include information that is based on the recipient's medical prognosis, and the life expectancy is six (6) months or less if the terminal illness runs its typical course.

(1) If a recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement from the hospice medical director or the physician member of the hospice interdisciplinary group before the [~~210 day~~] 210-day period expires.

(2) Hospice benefits furnished beyond the [~~210 day~~] 210-day period may be subject to medical review.

B. **Election of hospice care:** Recipients who are eligible for hospice care must elect to receive hospice services. Recipients or their legal representatives elect hospice services by filing an election statement with a particular hospice designee.

(1) For the duration of the election, recipients who elect hospice care, waive their right to medicaid payment for the following services:

(a) services related to treatment of the terminal condition or related condition for which hospice care was elected; and

(b) [~~hospice services furnished by nondesignated hospices; and~~

~~(c)~~] services equivalent to hospice care, such as home health services, and private duty nursing services under enhanced early and periodic screening, diagnosis and treatment (EPSDT) [~~, or home and community based waiver services~~].

(2) Recipients who are receiving home and community based waiver services or other in-home services based on a plan of care must have the plan of care coordinated with the hospice provider and adjusted as necessary to avoid duplicative or unnecessary services.

[~~(2)~~] (3) Hospice coverage continues for [~~210 day~~] 210-day time periods, as long as recipients remain in hospice care and do not cancel the election.

[~~(3)~~] (4) Recipients or their representatives can designate an effective date for the election. The effective date begins with the first or any subsequent day of hospice services.

C. **Election statement:** The election statement must include the following elements:

(1) designation of the hospice [~~which~~] that will provide care;

(2) designation of the recipient's attending physician;

(3) acknowledgement that the recipients or representatives has been given a full understanding of the palliative rather than curative nature of hospice care;

[~~(4) acknowledgement that certain medicaid services are waived by the election;~~

~~(5) effective date of the election; and~~

~~(6) signature of the recipient or representatives.~~]

(4) effective date of the election; and

(5) the recipient's or the representative's signature.

D. **Revocation of hospice care services:**

(1) A recipient or representative can cancel the election of hospice care at any time by filing a statement with MAD or its designee. The statement must include the following information:

(a) recipient is revoking his/her election for medicaid coverage of hospice care;

(b) effective date of the revocation, which is not earlier than the actual date of the revocation; and

(c) [~~signature of the recipient or their representative.~~] the recipient's or the representative's signature.

(2) Upon revocation of the election of hospice services, recipients are no longer covered for medicaid hospice services. [~~Medicaid coverage resumes for the services waived during election of hospice services.~~]

(3) Recipients can elect to receive hospice care services again at any time. The same process for approval of services must be followed when the second election occurs. A new plan of care, certification statement, and election [~~documentation~~] statement must be submitted to MAD or its designee.

E. **Change of designated hospice:**

(1) Recipients or their representatives can change designated hospice providers by filing statements with MAD or its designee. A statement must contain the following information:

(a) name of the hospice the recipient is leaving;

(b) name of the hospice the recipient is entering; and

(c) effective date of the change.

(2) A change in ownership or name of a hospice is not considered a change in the recipient's designated hospice.

[2/1/95; 8.325.4.12 NMAC - Rn, 8 NMAC 4.MAD.763.3 & A, 3-1-06]

8.325.4.13 COVERED SERVICES AND SERVICE LIMITATIONS: For [~~recipient~~] recipients electing hospice care, medicaid covers hospice core services furnished to eligible recipients [~~which~~] that are reasonable and necessary for the palliation or symptom management of a recipient's terminal illness and related conditions. Hospice core services include the medications, durable medical equipment and medical supplies needed to deliver palliative care. Hospice providers are reimbursed for the delivery of core services based on daily rate.

A. The hospice services necessary for a specific recipient must be documented in an individualized treatment plan. The plan must be developed by attending physicians, medical directors and interdisciplinary groups and must meet [~~the~~] certain requirements: See 42 CFR [~~Section 418 Subpart C~~] 418.50 et. seq..

(1) Hospices must designate a registered nurse to coordinate the implementation of each recipient's plan of care.

(2) The interdisciplinary group, including nursing services, medical social services, physician services and counseling services practitioners are responsible for the following:

(a) developing the plan of care;

(b) providing or supervising hospice care and services;

(c) reviewing and updating the plan of care; [~~and~~]

(d) establishing policies for daily provision of hospice care and services; and

(e) coordinating with other medicaid support service providers such that the plan of care is not duplicative of hospice services.

(3) All hospice services must be available twenty-four (24) hours per day to the extent necessary to meet the needs of the terminally ill recipients.

B. **Core services:** Medicaid covers the following nursing, medical social service, physician and counseling services as core hospice services:

(1) nursing [~~service~~] services furnished by or under the supervision of registered nurses and based on the treatment plan and recognized standards of practice;

(2) medical social services furnished by a qualified social worker under the direction of a physician;

(3) physician services performed by a doctor of medicine or osteopathy, including palliation and management of terminal illness and related conditions and the recipient's general medical needs not met by the recipient's attending physician;

(4) counseling services available to recipients and family members; counseling can be furnished for training families to provide care and preparing recipients and families to adjust to the recipient's approaching death; counseling includes dietary, spiritual and other counseling for recipients and families and bereavement counseling furnished after a recipient's death; the following counseling services must be furnished by hospices:

(a) organized program of bereavement services under the supervision of qualified professionals; the plan of care for these services must reflect family needs and provide a clear outline of the type, frequency and duration of counseling; bereavement counseling is a required but non-reimbursed service;

(b) dietary counseling, when applicable, furnished by qualified professionals;

(c) spiritual counseling, including notice to recipients of the availability of clergy; and

(d) other counseling, furnished by members of the interdisciplinary group or other qualified professionals.

(5) home health aide and homemaker services at frequencies sufficient to meet the needs of recipients; home health aides must meet training and qualification requirements; see 42 CFR [~~Section~~] 484.36; registered nurses must visit a recipient's residence every two (2) weeks to assess the performance of the aide or homemaker services;

(6) physical therapy, occupational therapy and speech-language therapy must be available if needed to control symptoms or maintain activities of daily living;

(7) durable medical equipment, medical supplies, and pharmacy services related to the palliation and management of the terminal illness and related conditions:

(a) See 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

(b) Medicaid covers only drugs and biologicals defined in Section 1861 (t) of the Social Security Act and used primarily for pain relief and symptom control related to terminal illness. All drugs and biologicals must be administered in accordance with accepted standards of practice.

(c) Every hospice must have a policy for the disposal of controlled drugs kept in the recipient's home when those drugs are no longer needed.

(d) Drugs and biologicals are to be administered only by the following individuals:

(i) a licensed nurse or physician;

(ii) the recipient with the approval of the attending physician; and

(iii) any other individual in accordance with applicable state and local laws; the individual and each drug and biological they are authorized to administer must be specified in the recipient's plan of care.

(8) short-term inpatient services for pain control and symptom management delivered in a facility which is a medicaid provider; and

(9) short-term inpatient respite services furnished in a facility which is a medicaid provider; medicaid covers five (5) consecutive days of inpatient respite care which can be needed on an infrequent basis to provide respite for the recipient's family or primary caregivers.

(a) The need for and duration of inpatient respite services must be specified in the treatment plan.

(b) Inpatient respite must be furnished by a hospice facility, hospital, or nursing facility [~~which meets requirements. See~~] that meets the requirements in 42 CFR Section 418.100 [~~(a)(f)~~].

C. **Continuous nursing care services:** Medicaid covers continuous nursing care required to achieve pain control and symptom management. Continuous care can be covered during a period of crisis if the recipient needs such care to achieve palliation and manage acute medical symptoms at home.

(1) To be considered continuous care, nursing care must be furnished for eight (8) consecutive hours in a twenty-four (24) hour period. Medicaid covers the homemaker and/or aide services furnished during the other sixteen (16) hours as routine home care.

(2) Medicaid covers continuous nursing services for a maximum of seventy-two (72) consecutive hours.

[2/1/95; 8.325.4.13 NMAC - Rn, 8 NMAC 4.MAD.763.4 & A, 3-1-06]

8.325.4.14 PRIOR [~~APPROVAL~~] AUTHORIZATION AND UTILIZATION REVIEW: Hospice services are subject to utilization review for medical necessity and program compliance. These reviews can be performed before services are furnished, after services are furnished and before payment is made, after payment is made, or at any point in the service or payment process. See 8.302.5 NMAC, *Prior [~~Approval~~] Authorization and Utilization Review*. Once enrolled, providers receive utilization review instructions and documentation forms which assists in the receipt of prior [~~approval~~] authorization and claims processing.

A. **Prior [~~approval~~] authorization:** Hospice services do not require prior [~~approval~~] authorization. Services remain subject to review at any point in the payment process for medical necessity.

B. **Eligibility determination:** Prior [~~approval~~] authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers [~~or recipients~~] who are dissatisfied with a utilization review decision or action can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[2/1/95; 8.325.4.14 NMAC - Rn, 8 NMAC 4.MAD.763.5 & A, 3-1-06]

8.325.4.15 NONCOVERED SERVICES: Hospice services are subject to the limitations and coverage restrictions [~~which~~] that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. Medicaid does not cover the following hospice services.

A. Core services furnished by nonemployees. Core services when furnished routinely by non-employees or contracted staff are not covered by medicaid. A hospice can bill only for contracted staff necessary to supplement hospice employees in meeting recipient needs during periods of peak patient loads.

B. Bereavement counseling furnished to families after a recipient's death is a required hospice service, however, hospice agencies are not paid an additional amount for furnishing these services [~~; and~~].

C. Inpatient respite care for more than five (5) consecutive days. After five (5) days, additional inpatient respite care is reimbursed as routine home care. Respite care cannot be furnished if the recipient lives in a long-term care facility.

D. Hospice services furnished by nondesignated hospices are not a covered benefit.

[2/1/95; 8.325.4.15 NMAC - Rn, 8 NMAC 4.MAD.763.6 & A, 3-1-06]

8.325.4.17 REIMBURSEMENT: Hospice providers must submit claims for reimbursement on the UB-92 claim form or its successor. Election documentation must be submitted with the initial claim. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Medicaid reimbursement for hospice care is made at one of four prospective daily rates, depending on the level of care furnished. The only retroactive adjustment to reimbursement is the year-end application of the limitation on inpatient care payment. Physician services are reimbursed separately from the hospice daily rate.

A. **Payment for hospice care:**

(1) Payment rates for hospice care services are determined by the [~~health care financing administration (HCFA)~~] centers for medicare and medicaid services (CMS), with local adjustments for wage differences within each category. Reimbursement for hospice services is based on one of four all-inclusive daily rate categories. The daily rate for each category includes all services necessary for palliative care, such as the purchase of needed medications, durable medical equipment, and medical supplies. The following are basic categories of hospice care:

(a) "routine home care day" defined as a day on which the recipient receives hospice care at home [~~which~~] that is not defined as continuous care;

(b) "continuous home care day" defined as a day on which the recipient is not in an inpatient facility and receives nursing services for eight (8) consecutive hours in a twenty-four (24) hour period; this care is furnished only during brief periods of crisis to maintain the recipient at home; home health aide and/or homemaker services can also be furnished on a continuous basis, but these services are considered routine care;

(c) "inpatient respite care day" defined as a day on which a recipient receives care in approved facilities on a short-term basis to provider respite for the recipient's family or primary caregiver; and

(d) "general inpatient care day" defined as a day on which a recipient receives care in inpatient facilities for pain control or acute or chronic symptom management [~~which~~] that cannot be managed in other settings.

(2) Reimbursement is made to a hospice for each day on which recipients are eligible for hospice care. Reimbursement is based on the appropriate payment amount for each day, regardless of the category of services furnished on any given day.

(3) Reimbursement for a continuous home care day varies, depending on the number of hours of continuous nursing services furnished. The continuous home care rate is divided by twenty-four (24) to yield an hourly rate. The number of hours of care furnished during the continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. Medicaid reimbursement for continuous home care is limited to a maximum of seventy-two (72) consecutive hours of service.

(4) The inpatient reimbursement rate for approved facility for short-term inpatient care depends on the category of care furnished, either inpatient respite or general inpatient.

(a) Reimbursement for inpatient respite care is limited to a maximum of five (5) consecutive days at a time. Medicaid pays for the sixth and any subsequent day of respite care at the routine home care rate.

(b) Medicaid pays the inpatient rate for the admission date and all subsequent inpatient days. For the discharge day, the applicable home care rate is reimbursed. Reimbursement for the discharge day when the recipient is discharged deceased is made at the inpatient rate.

(c) Reimbursement for all inpatient care is subject to a limitation that total inpatient care days for medicaid recipients cannot exceed twenty percent (20%) of the total days for which these recipients elected hospice care. The calculation and any necessary retroactive adjustment of overall payments per provider is completed during

the cap period. See 42 CFR [~~Section~~] 418.302 (f).

B. **Reimbursement for physician services:**

(1) Medicaid covers the following services performed by hospice physicians as part of the general reimbursement rate for hospice care services:

(a) general supervisory services of the medical director; and

(b) participation in establishing, reviewing and updating plans of care, supervision of care and services, and establishment of governing policies by the physician member of the interdisciplinary group.

(2) For direct patient care services furnished by a hospice employee or a physician working under arrangement with the hospice, not listed above, medicaid reimburses the hospice for each procedure at the lesser of the medicaid fee schedule or the amount billed.

(3) Medicaid does not pay for physician services furnished on a volunteer basis.

(4) Medicaid does not cover physician services furnished by the recipient's attending physician as a hospice service, if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Only the attending physician can bill for these services.

[2/1/95; 8.325.4.17 NMAC - Rn, 8 NMAC 4.MAD.763.8 & A, 3-1-06]

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 12 PUBLIC SCHOOL ADMINISTRATION - HEALTH AND SAFETY
PART 5 NUTRITION: COMPETITIVE FOOD SALES

6.12.5.1 ISSUING AGENCY: Public Education Department
[6.12.5.1 NMAC - N, 02-28-06]

6.12.5.2 SCOPE: This rule applies to public schools in New Mexico unless otherwise expressly limited.
[6.12.5.2 NMAC - N, 02-28-06]

6.12.5.3 STATUTORY AUTHORITY: This rule is adopted pursuant to Sections 22-2-1 and 9-24-8, NMSA 1978.
[6.12.5.3 NMAC - N, 02-28-06]

6.12.5.4 DURATION: Permanent
[6.12.5.4 NMAC - N, 02-28-06]

6.12.5.5 EFFECTIVE DATE: February 28, 2006, unless a later date is cited at the end of a section.
[6.12.5.5 NMAC - N, 02-28-06]

6.12.5.6 OBJECTIVE: This rule addresses the sale of competitive food sold to children attending public schools in New Mexico.
[6.12.5.6 NMAC - N, 02-28-06]

6.12.5.7 DEFINITIONS:

A. "A la carte" means a beverage or food product sold in schools to students during the lunch period that is not part of the United States department of agriculture school meal program.

B. "Competitive food" means a food or beverage sold at school other than one served as part of the United States department of agriculture school meal program. The term includes any item sold in vending machines, a la carte or through other school fundraising efforts.

C. "Fund raisers" means beverage or food products sold to raise money that are not sold in vending machines, a la carte sales or as part of the United States department of agriculture school meal program.

D. "Vended beverages and foods" means a beverage or food product sold in vending machines to students in schools.
[6.12.5.7 NMAC - N, 02-28-06]

6.12.5.8 REQUIREMENTS FOR COMPETITIVE FOODS SOLD TO STUDENTS:

A. Vended foods and beverages:

(1) Elementary schools:

(a) Beverages sold in vending machines to students in elementary schools shall only be sold after the last lunch period is completed and shall only include:

(i) milk with a fat content of 2 percent or less;

(ii) soy milk; and

(iii) water.

(b) Carbonated beverages shall not be sold in vending machines to students in elementary schools.

(c) Food products shall not be sold in vending machines to students in elementary schools.

(2) Middle schools:

(a) Beverages sold in vending machines to students in middle schools shall only include:

(i) milk with a fat content of two percent or less;

(ii) soy milk;

(iii) water; and

(iv) 100 percent fruit juice that has no added sweeteners and no more that 125 calories per container and a serving size not to exceed 20 ounces.

(b) Carbonated beverages shall not be sold in vending machines to students in middle schools.

(c) Food products sold in vending machines to students in middle schools are subject to the following requirements:

(i) Nuts, seeds, cheese, yogurt, and fruit may be sold in vending machines in middle schools at any time and are not subject to the restrictions in item (ii) of this subparagraph.

(ii) Food products other than those listed in item (i) of this subparagraph shall only be sold after the last lunch period is completed and are subject to the following restrictions: shall contain no more than 200 calories per container or per package or amount served and shall contain no more than 8 grams of fat per container or per package or amount served with no more than 2 grams of fat from saturated and trans-fats and shall contain no more than 15 grams of sugar per package or amount served.

(3) High schools:

(a) Beverages sold in vending machines to students in high schools at any time shall only include:

(i) milk with a fat content of 2 percent or less;

(ii) soy milk;

(iii) water; and

(iv) juice that is at least 50 percent fruit and that has no added sweeteners and a serving size not to exceed 20 ounces.

(b) Beverages sold in vending machines to students in high schools after the last lunch period is completed shall only include the items in subparagraph (a) and:

(i) carbonated soft drinks that are both sugar free and caffeine free;

(ii) non-carbonated flavored water with no added sweeteners; and

(iii) sports drinks.

(c) Food products sold in vending machines to students in high schools may be sold at any time subject to the following requirements:

(i) Nuts, seeds, cheese, yogurt, and fruit may be sold in vending machines in high schools at any time and are not subject to the restrictions in item (ii) of this subparagraph.

(ii) Food products other than those listed in item (i) of this subparagraph are subject to the following restrictions: shall contain no more than 200 calories per container or per package or amount served and shall contain no more than 8 grams of fat per container or per package or amount served with no

more than 2 grams of fat from saturated and trans-fats and shall contain no more than 15 grams of sugar per container or per package or amount served.

B. A la carte offerings must meet the following requirements:

(1) Beverages sold in a la carte offerings may only be sold during lunch period and shall only include:

(a) Elementary schools:

(i) milk with a fat content of 2 percent or less;

(ii) soy milk; and

(iii) water.

(b) Middle schools:

(i) milk with a fat content of two percent or less;

(ii) soy milk;

(iii) water; and

(iv) 100 percent fruit juice that has no added sweeteners and no more that 125 calories per container and a serving size not to exceed 20 ounces.

(c) High schools:

(i) milk with a fat content of 2 percent or less;

(ii) soy milk;

(iii) water; and

(iv) juice that is at least 50 percent fruit and that has no added sweeteners and a serving size not to exceed 20 ounces.

(2) Carbonated beverages or soft drinks, non-carbonated flavored water and sports drinks shall not be sold in a la carte offerings.

(3) Food products sold in a la carte offerings may only be sold during lunch and are subject to the following requirements:

(a) Nuts, seeds, cheese, yogurt, and fruit are not subject to the restrictions in subparagraph (b) of this paragraph.

(b) Food products other than those listed in subparagraph (a) of this paragraph are subject to the following restrictions:

(i) shall contain no more than 400 calories per container or per package or amount served; and

(ii) shall contain no more than 16 grams of fat per container or per package or amount served, of which no more than 2 grams come from saturated and trans fats combined; and

(iii) shall contain no more than 30 grams of total sugar per package or amount served.

C. Fund raisers:

(1) Beverages and food products may be sold as fund raisers at any time during normal school hours except during the lunch period and are subject to the following requirements and limitations:

(a) Elementary schools:

(i) Beverages sold shall only include: milk with a fat content of 2 percent or less; soy milk; and water. Carbonated beverages shall not be sold.

(ii) Food products shall not be sold as fund raisers to students in elementary schools.

(b) Middle schools:

(i) Beverages sold shall only include: milk with a fat content of 2 percent or less; soy milk; water; and one hundred percent fruit juice that has no added sweeteners and no more that 125 calories per container and a serving size not to exceed 20 ounces. Carbonated beverages shall not be sold.

(ii) Food products sold are subject to the following requirements: nuts, seeds, cheese, yogurt, and fruit may be sold and are not subject to restrictions; food products other than nuts, seeds, cheese, yogurt and fruit shall contain no more than 200 calories per container or per package or amount served and shall contain no more than 8 grams of fat per container or per package or amount served with no more than 2 grams of fat from saturated and trans-fats and shall contain no more than 15 grams of sugar per container or per package or amount served.

(c) High schools:

(i) Beverages sold shall only include: milk with a fat content of 2 percent or less, soy milk, water and juice that is at least 50 percent fruit and that has no added sweeteners and a serving size not to exceed 20 ounces.

(ii) Food products sold are subject to the following requirements: nuts, seeds, cheese, yogurt, and fruit may be sold and are not subject to restrictions; food products other than nuts, seeds, cheese, yogurt and fruit shall contain no more than 200 calories per container or per package or amount served and shall contain no more than 8 grams of fat per container or per package or amount served with no more than 2 grams of fat from saturated and trans-fats and shall contain no more than 15 grams of sugar per container or per package or amount served.

(2) Beverages and food products may be sold as fund raisers outside of normal school hours provided that at least 50 per cent of the offerings meet the following requirements:

(a) Beverages: milk with a fat content of 2 percent or less; soy milk, water and juice that is at least 50 percent fruit and that has no added sweeteners and a serving size not to exceed 20 ounces.

(b) Food products: nuts, seeds, cheese, yogurt, and fruit may be sold and are not subject to restrictions; food products other than nuts, seeds, cheese, yogurt and fruit shall contain no more than 200 calories per container or per package or amount served and shall contain no more than 8 grams of fat per container or per package or amount served with no more than 2 grams of fat from saturated and trans-fats, and shall contain no more than 15 grams of sugar per container or per package or amount served.

[6.12.5.8 NMAC - N, 02-28-06]

History of 6.12.5 NMAC: [Reserved]

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 12 PUBLIC SCHOOL ADMINISTRATION - HEALTH AND SAFETY
PART 6 SCHOOL DISTRICT WELLNESS POLICY

6.12.6.1 ISSUING AGENCY: Public Education Department
[6.12.6.1 NMAC - N, 02-28-06]

6.12.6.2 SCOPE: This regulation applies to public schools in New Mexico unless otherwise expressly limited.
[6.12.6.2 NMAC - N, 02-28-06]

6.12.6.3 STATUTORY AUTHORITY: This regulation is adopted pursuant to Sections 22-2-1 and 9-24-8 NMSA 1978.
[6.12.6.3 NMAC - N, 02-28-06]

6.12.6.4 DURATION: Permanent
[6.12.6.4 NMAC - N, 02-28-06]

6.12.6.5 EFFECTIVE DATE: February 28, 2006, unless a later date is cited at the end of a section.
[6.12.6.5 NMAC - N, 02-28-06]

6.12.6.6 OBJECTIVE: This rule requires the adoption of local school district wellness policies.
[6.12.6.6 NMAC - N, 02-28-06]

6.12.6.7 DEFINITIONS:

A. "Coordinated school health approach" means the framework for linking health and education. The focus is healthy and successful students. There are eight interactive components of coordinated school health: health education; physical education and activity; nutrition; social and emotional well-being; healthy and safe environment; health services; staff wellness; and family, school and community involvement.

B. "Family, school and

community involvement" means an integrated family, school and community approach for enhancing the health and well-being of students by establishing a district school health advisory council that has the responsibility to make recommendations to the local school board in the development or revision, implementation, and evaluation of the wellness policy.

C. "Health education" means the instructional program that provides the opportunity to motivate and assist all students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. It meets the content standards with benchmarks and performance standards as set forth in 6.30.2.19 NMAC.

D. "Health services" means services provided for students to appraise, protect, and promote health. These services are designed to ensure access or referral to primary health care or behavioral health services or both, foster appropriate use of primary health care services, behavioral health services, prevent and control communicable diseases and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment, and provide educational and counseling opportunities for promoting and maintaining individual, family, and community health.

E. "Healthy and safe environment" means the physical and aesthetic surroundings and the psychosocial climate and culture of the school. It supports a total learning experience that promotes personal growth, healthy interpersonal relationships, wellness, and freedom from discrimination and abuse.

F. "Nutrition" means programs that provide access to a variety of nutritious and appealing meals and snacks that accommodate the health and nutrition needs of all students.

G. "Physical activity" means body movement of any type which include recreational, fitness, and sport activities.

H. "Physical education" means the instructional program that provides cognitive content and learning experiences in a variety of activity areas. It provides the opportunity for all students to learn and develop the skills, knowledge and attitudes necessary to personally decide to participate in a lifetime of healthful physical activity. It meets the content standards with benchmarks and performance standards as set forth in Section 6.30.2.20 NMAC.

I. "Social and emotional wellbeing" means services provided to maintain and/or improve students' mental, emotional, behavioral, and social health.

J. "Staff wellness" means opportunities for school staff to improve their health status through activities such as health assessments, health education and health-related fitness activities. These opportunities encourage school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated school health approach.

[6.12.6.7 NMAC - N, 02-28-06]

6.12.6.8 REQUIREMENTS:

A. This section applies to local school boards, local school districts, and charter schools and governs policies to be implemented by local school districts with regards to student and school employee wellness.

B. Each school district and charter school shall develop and implement a policy that addresses student and school employee wellness through a coordinated school health approach.

C. Each school district and charter school shall submit the wellness policy to the public education department for approval.

(1) Sections of the wellness policy that meet the requirements set forth in Paragraphs (3), (4), (5), (6) and (11) of Subsection D and the requirements set forth in Subsection E of this section shall be submitted to the public education department on or before August 30, 2006.

(2) Sections of the wellness policy that meet the requirements set forth in Paragraphs (1), (2), (7), (8), (9) and (10) of Subsection D of this section shall be submitted to the public education department on or before January 30, 2007.

D. The wellness policy shall include, but shall not be limited to:

(1) a planned, sequential, K-12 health education curriculum that addresses the physical, mental, emotional, and social dimensions of health and is aligned to the health education content standards with benchmarks and performance standards as set forth in 6.30.2.19 NMAC;

(2) a planned, sequential, K-12 physical education curriculum that provides the optimal opportunity for all students to learn and develop skills, knowledge and attitudes necessary to personally decide to participate in lifetime healthful physical activity and is aligned to the physical education content standards with benchmarks and performance standards as set forth in 6.30.2.20 NMAC;

(3) guidelines to provide physical activity opportunities to students before, during and/or after school;

(4) nutrition guidelines for a la carte offerings minimally meeting guidelines set forth in Subsection B of 6.12.5.8 NMAC;

(5) guidelines for school sponsored fund raisers during the normal school hours minimally meeting guidelines set forth in Paragraph (1) of Subsection C of 6.12.5.8 NMAC;

(6) guidelines for school sponsored fund raisers before and after schools hours ensuring that at least fifty percent of the offerings shall be healthy choices in accordance with the requirements set forth in Paragraph (2) of Subsection C of 6.12.5.8 NMAC;

(7) a plan addressing the behavioral health needs of all students in the educational process by focusing on students' social and emotional wellbeing;

(8) school safety plans at each school building focused on supporting healthy and safe environments and including but not necessarily limited to prevention, policies and procedures, and emergency response;

(9) a plan addressing the health services needs of students in the educational process;

(10) a plan addressing the staff wellness needs of all school staff that minimally ensures an equitable work environment and meets the American with Disabilities Act, Part III;

(11) a plan for measuring implementation and evaluation of the wellness policy, including the designation of one or more persons within the school district, or at each school, as appropriate, charged with operational responsibility for ensuring that each school fulfills the district's wellness policy.

E. Family, school and community involvement. Each local board of education shall establish a district school health advisory council that consists of parent(s), school food authority personnel, school board member(s), school administrator(s), school staff; student(s); and community member(s). The school health advisory council shall have the responsibility to make recommendations to the local school board in the development or revision, implementation, and evaluation of the wellness policy consistent with this rule. The school health advisory council shall meet for this purpose a minimum of two times annually.

[6.12.6.8 NMAC - N, 02-28-06]

History of 6.12.6 NMAC: [Reserved]

NEW MEXICO PUBLIC EDUCATION DEPARTMENT

This is an amendment to 6.64.6 NMAC, Sections 1, 2, 5, 6, and 8 through 10, effective 02-28-06. The part name is also amended

PART 6 COMPETENCIES FOR ENTRY-LEVEL [~~SOCIAL STUDIES~~] HISTORY, GEOGRAPHY, ECONOMICS, CIVICS AND GOVERNMENT TEACHERS

6.64.6.1 ISSUING AGENCY: [~~State Board of Education~~] Public Education Department
[07-15-99; 6.64.6.1 NMAC - Rn, 6 NMAC 4.7.1.5.1, 10-31-01; A, 02-28-06]

6.64.6.2 SCOPE: Chapter 64, Part 6, governs the competencies that will be used by New Mexico institutions of higher education to establish a curriculum for persons seeking an endorsement in [~~social studies~~] history, geography, economics, civics and government to a New Mexico educator license.
[07-15-99; 6.64.6.2 NMAC - Rn, 6 NMAC 4.7.1.5.2, 10-31-01; A, 02-28-06]

6.64.6.5 EFFECTIVE DATE: July 15, 1999, unless a later date is cited at the end of a section [~~or paragraph~~].
[07-15-99; 6.64.6.5 NMAC - Rn, 6 NMAC 4.7.1.5.5, 10-31-01; A, 02-28-06]

6.64.6.6 OBJECTIVE: This regulation is adopted by the [~~state board of education~~] public education department (hereinafter the "[~~state board~~] PED") for the purpose of establishing entry-level [~~social studies~~] competencies that are based on what beginning [~~social studies~~] history, geography, economics, civics and government teachers must know and be able to do to provide effective [~~social studies~~] history, geography, economics, civics and government programs in New Mexico K-12 schools. The competencies were developed to ensure alignment with the New Mexico's content standards and benchmarks for social studies and with the national standards of the national council for [~~the~~] social studies.
[07-15-99; 6.64.6.6 NMAC - Rn, 6 NMAC 4.7.1.5.6, 10-31-01; A, 02-28-06]

6.64.6.8 REQUIREMENTS:

A. Beginning teachers seeking an endorsement in [~~social studies~~] history, geography, economics, civics and government to an initial level I New Mexico teaching license, must satisfy all of the requirements of the license as provided in [~~state board of education~~] PED rule for that license, which includes, among other requirements, 24-36 semester hours [~~in social studies~~] from among history, geography, economics, civics and government and other social sciences and passage of a content area test [~~in social studies~~] that examines the candidate's knowledge of history, geography, economics, civics and government.

B. Teachers seeking to add an endorsement in [~~social studies~~] history, geography, economics, civics and government to an existing New Mexico teaching license of any level where the candidate has less than five full academic years of teaching experience shall meet one of the following requirements:

(1) pass the content knowledge test(s) of the New Mexico teacher assessments as provided in 6.60.5.8 NMAC, or predecessor New Mexico teacher licensure examination or accepted comparable licensure test(s) from another state in [~~social studies~~] history, geography, economics, civics and government; or

(2) successfully complete an undergraduate academic major (24-36 semester hours), or coursework equivalent to an undergraduate major or a graduate degree in [~~social studies~~] history, geography, economics, civics or government; or

(3) obtain certification in social studies which includes content knowledge in history, geography, economics, civics and government for the appropriate grade level of New Mexico licensure from the national board for professional teaching standards.

C. Persons seeking to add an endorsement in [~~social studies~~] history, geography, economics, civics and government to an existing New Mexico teaching license of any level where the candidate has at least five full academic years of teaching experience, may do so by meeting the requirements of Paragraphs (1), (2) or (3) of Subsection B of 6.64.6.8 NMAC, or by demonstrating the teaching competencies for entry level [~~social studies~~] history, geography, economics, civics and government teachers as provided in 6.64.6.9 NMAC through the state's high objective uniform statewide standard of evaluation ([~~HOUSE~~] HOUSSE) for demonstrating competence in the core academic subjects and other endorsement areas as set forth in 6.69.4.9 NMAC.
[07-15-99; 6.64.6.8 NMAC - Rn, 6 NMAC 4.7.1.5.8, 10-31-01; A, 09-30-03; A, 02-28-06]

6.64.6.9 COMPETENCIES FOR ENTRY-LEVEL [~~SOCIAL STUDIES~~] HISTORY, GEOGRAPHY, ECONOMICS, CIVICS AND GOVERNMENT TEACHERS:

A. How the world's people cope with ever-changing conditions, examine issues from multiple perspectives, and respond to individual and cultural diversity. Teachers will demonstrate a working knowledge of how:

(1) political, social, economic, historical, and geographic aspects distinguish New Mexico's uniqueness;

(2) the United States developed as a nation including the struggles, accomplishments and roles of individuals and/or groups as the United States emerged to be a leader of nations;

(3) nations share commonalties and differences and that these influences within nations generate their direction and distinction;

(4) critical information, ideas, and concepts are common across societies, social institutions, cultures, and cultural perspectives.

B. The purpose of democratic and civic values which act in accordance with democratic processes and principles to protect individual rights, promote the common good, and become an effective United States citizen. Teachers will demonstrate a working knowledge of how:

(1) to gather, interpret, and report on political processes in New Mexico at the local, state, tribal, and federal levels;

(2) to compare and contrast the emergence of different types of governments in the world;

(3) to analyze factors that continue to support democratic processes and principles exemplified by the United States constitution.

C. The use of language, tools, and skills of social studies. Teachers will demonstrate a working knowledge of how to:

(1) use social studies vocabulary and concepts;

(2) analyze the reliability and validity of social studies information sources;

(3) interpret and report social studies information from diverse sources (e.g., people, media, technology, the internet, and libraries);

(4) evaluate the roles of citizens and their involvement in civic projects with emphasis on the United States;

(5) locate, access, organize, analyze, synthesize, evaluate, and apply information about selected public issues - identifying, describing, and evaluating multiple points of view.

D. The ways in which human beings view themselves and others over time. Teachers will demonstrate a working knowledge of:

(1) varying perspectives in histor-

ical writing;

(2) how to evaluate historical inquiry as influenced by culture and society;

(3) how to analyze historical periods of change within and across cultures.

E. Understand relationships and patterns in history in order to understand the past and present and to prepare for the future. Teachers will demonstrate a working knowledge of:

(1) the use of facts and concepts drawn from history along with methods of historical inquiry to make informed decisions and take appropriate action on public issues with emphasis on the United States;

(2) the historical, political, economic, and social developments of various cultural groups in the world;

(3) key concepts (e.g. time, causality, conflict, and complexity) to identify, analyze, and explain connections among patterns of historical change and continuity.

F. How personal and group identities are shaped by culture, physical environment, individuals, groups and institutions. Teachers will demonstrate a working knowledge of:

(1) the concepts of role, status, culture, and social class and will use them in describing the connections and interactions of individuals, groups, and institutions in society with emphasis on the United States;

(2) how perceptions, attitudes, values, and beliefs affect the development of personal identity and decision making;

(3) how media and expanding technology (e.g. print, Internet, film, television, and radio) affect the development of personal identity and decision making;

(4) group and institutional influences on people, events, and elements of culture in both historical and contemporary settings.

G. Historical developments of structures of power, authority, governance and the forms and purposes of governments in the world with emphasis on principles, ideals, and forms of governments of the United States. Teachers will demonstrate a working knowledge of:

(1) the organization of governments (local, state, tribal, and national) and the services they provide;

(2) historical development of the different forms of government, with emphasis on the principles and ideals of the United States;

(3) key concepts (e.g. power, role, status, justice, and influence) in order to examine persistent issues and social problems.

H. The responsibilities, rights and privileges of United States citizens. Teachers will demonstrate a working knowledge of:

(1) the rights, responsibilities, and privileges of the individual, in relation to family, social group, career, community, and nation;

(2) the continuing influence of the key ideas of individual human dignity, liberty, justice, equality, and the rule of law;

(3) how to identify, analyze, interpret, and evaluate sources and examples of citizens' rights, responsibilities, and privileges;

(4) connections of social studies content to career readiness.

I. To develop and employ the civic skills necessary for participatory citizenship. Teachers will demonstrate a working knowledge of:

(1) forms of civic discussion and participation consistent with the ideals of United States citizens;

(2) the influence of various forms of citizen action on public policy;

(3) influences of public opinion on policy development and decision-making;

(4) how to evaluate ways in which public policies and citizen behaviors reflect the ideals of a democratic republican form of government.

J. The impact of economic systems and institutions on individuals, families, careers, businesses, communities, and governments. Teachers will demonstrate a working knowledge of:

(1) the roles and influences of economic institutions on career choice and opportunity;

(2) roles and relationships of the various economic institutions that comprise economic systems (e.g. households, business firms, banks, government agencies, labor unions, corporations, etc.);

(3) the impact of economic systems and institutions on individuals, families, businesses, communities and governments including monetary systems, law of supply and demand, and entrepreneurship;

(4) the domestic and global economic systems and how they interact.

K. The diverse, dynamic, and ever-changing nature of culture. Teachers will demonstrate a working knowledge of:

(1) how language, literature, the arts, media, architecture, artifacts, traditions, beliefs, values, and behaviors interact and contribute to the development and transmission of culture;

(2) societal patterns for preserving and transmitting culture, while adapting to environmental or social change;

(3) the importance of cultural unity and diversity within and across groups;

(4) ideas, theories, and modes of inquiry drawn from anthropology, psychology and sociology in the examination of how issues of gender and ethnicity affect intercultural understanding.

L. Physical environments and their relationships to ecosystems and human activities. Teachers will demonstrate a working knowledge of:

(1) the relationships among varying regional and global patterns of geographic phenomena (e.g. landforms, climate, and natural resources) and the interactions of human beings and their physical environment;

(2) how earth's physical features have changed over time and how historical events have influenced and have been influenced by physical and human geographic features;

(3) the interrelationships of physical and cultural patterns that reflect land use, settlement patterns, ecosystem changes and cultural transmission of customs and ideas;

(4) geographic tools and resources to generate and interpret information;

(5) the complexity of social and economic effects of environmental change and crises.

M. The impact of science and technology on societies. Teachers will demonstrate a working knowledge of:

(1) how science and changing technology have transformed the physical world and human society;

(2) how science and technologies influence and are influenced by core values, ethics, beliefs, and attitudes of society, including public policies with emphasis on the United States;

(3) the interdependence of science, technology, and society in a variety of cultural settings.

N. The role of global connections and interdependence between and among individuals, groups, societies, and nations. Teachers will demonstrate a working knowledge of:

(1) how interactions among the arts, language, technology, belief systems, and other cultural elements can impact global understanding;

(2) relationships and tensions between national sovereignty and international interests in such matters as territory, economic development, use of natural resources, nuclear and other weapons, and concerns about human rights.

O. In addition to the general licensure requirements on assessment the secondary [~~social studies~~] teacher <u>of history, geography, economics, civics and government</u> should possess the following capabilities, disposition, and knowledge to assess student learning. Teachers will demonstrate a working knowledge of:

(1) checking for understanding;

(2) describing and demonstrating;
(3) comparing and contrasting;
(4) analyzing and evaluating;
(5) inferring and interpreting;
(6) thinking chronologically;
(7) predicting, speculating and extrapolating.

[07-15-99; 6.64.6.9 NMAC - Rn, 6 NMAC 4.7.1.5.9, 10-31-01; A, 02-28-06]

6.64.6.10 IMPLEMENTATION: Institutions of higher education that prepare teachers shall deliver the competencies in a [~~state board~~] PED approved endorsement program within a range of twenty-four (24) to thirty-six (36) semester hours of credit twelve (12) semester hours of which must be upper division credit.

[07-15-99; 6.64.6.10 NMAC - Rn, 6 NMAC 4.7.1.5.10, 10-31-01; A, 02-28-06]

NEW MEXICO PUBLIC REGULATION COMMISSION

TITLE 17 PUBLIC UTILITIES AND UTILITY SERVICE
CHAPTER 11 TELECOMMUNICATIONS
PART 23 RETAIL SERVICE PRICING STANDARDS FOR MID-SIZE CARRIERS

17.11.23.1 ISSUING AGENCY: The New Mexico Public Regulation Commission.

[17.11.23.1 NMAC - N, 4-1-2006]

17.11.23.2 SCOPE: This rule applies to all mid-size carriers.

[17.11.23.2 NMAC - N, 4-1-2006]

17.11.23.3 STATUTORY AUTHORITY: NMSA 1978 Sections 63-9A-5.1 and 63-9A-5.2.

[17.11.23.3 NMAC - N, 4-1-2006]

17.11.23.4 DURATION: Permanent.

[17.11.23.4 NMAC - N, 4-1-2006]

17.11.23.5 EFFECTIVE DATE: April 1, 2006, unless a later date is cited at the end of a section.

[17.11.23.5 NMAC - N, 4-1-2006]

17.11.23.6 OBJECTIVE: The purpose of this rule is to establish retail service pricing standards for mid-size carriers.

[17.11.23.6 NMAC - N, 4-1-2006]

17.11.23.7 DEFINITIONS: As used in this rule:

A. basic services means retail telecommunications services that provide residence or business customers with an individual primary line providing voice grade access to the public switched network;

B. basket means a collection of retail telecommunications services grouped together in order to calculate permissible changes in the price ceilings for the services;

C. bundle means a combination of regulated services and unregulated services in a single retail product offering; the unregulated services may be obtained by a mid-size carrier from another entity;

D. commission notice means a letter of notice filed by a mid-size carrier at the New Mexico public regulation commission;

E. cost means the cost incurred by a mid-size carrier to provide a service in New Mexico;

F. customer notice means notice of changes in service prices, terms, or conditions provided by a mid-size carrier to retail customers via bill message or, at the option of the mid-size carrier, via bill insert, direct mail, or publication in newspapers;

G. effective price means the current tariffed price for a retail telecommunications service;

H. initial price means a mid-size carrier's rates on file at the commission on the first date that the carrier is regulated under this rule. The first established price of a new service introduced after the effective date of this rule shall be considered its initial price;

I. mid-size carrier means any telecommunications company with more than fifty thousand but less than three hundred seventy-five thousand access lines in New Mexico;

J. non-basic services means retail telecommunications services that are not a basic service, a switched access service or a wholesale service governed by an interconnection agreement;

K. package means the combination of two or more regulated services in a single retail product offering by a mid-size carrier;

L. price ceiling means the maximum price at which a basic or non-basic service may be offered;

M. price floor means the lowest price at which a basic or non-basic service may be offered;

N. promotion means the offering of a new or existing telecommunications product or service at a new or reduced price or on modified terms for a temporary period;

O. service area refers to the territory served by a mid-size carrier within a single wire center.

[17.11.23.7 NMAC - N, 4-1-2006]

17.11.23.8 PRICING FLEXIBILITY: In recognition of factors that distinguish mid-size carriers from other carriers, this rule establishes pricing flexibility for mid-size carriers and an objective mechanism by which mid-size carriers may adjust prices.

A. Basic Services.

(1) Effective Price. The effective price of a basic service may be any price that is less than or equal to the price ceiling for the service and greater than or equal to the price floor for the service.

(2) Price Ceilings.

(a) The initial price ceiling for each basic service shall be its initial price.

(b) Each price ceiling shall be adjusted once annually by the percentage change in the average national price for residential and business single lines reported in the most recent statistics of communications common carriers published by the federal communications commission.

(i) For residential and business customers, price indices shall be calculated based on the tables entitled "average residential rates for local service in urban areas" and "average local rates for businesses with a single line in urban areas," respectively.

(ii) For residential and business customers, the applicable price indices shall be calculated based on the rows entitled "total monthly charge" and "total connection charge."

(c) If the index declines in a year, the price ceiling shall not be reduced; however, the price ceiling will not be increased subsequently until the index surpasses its value in the year prior to the decline.

(d) A mid-size carrier may change the price ceiling of a basic service by filing tariff sheets reflecting the change and providing notice as required in17.11.23.9 NMAC.

(3) Price Floors. The price floor for a basic service shall be the average cost of providing the service in New Mexico.

(4) Rebalancing. The commission may revise the price ceiling for a basic service as part of a revenue-neutral rate rebalancing, as provided by NMSA 1978 Section 63-9A-5.1(E). Subsequent changes to a revised price ceiling shall be based on subsequent changes in the appropriate index.

B. Non-Basic Services.

(1) Effective Price. The effective price of a non-basic service may be any price that is less than or equal to the price floor for the service.

(2) Price Ceilings.

(a) The initial price ceiling for each non-basic service shall be its initial

price.

(b) A mid-size carrier may change the price ceiling of a non-basic service by providing notice.

(c) An increase in the price ceiling for a non-basic service other than a custom calling service will be presumed to be reasonable and will be permitted to become effective by the commission if the increase is not greater than five percent in any twelve-month period.

(d) For purposes of calculating changes to price ceilings for custom calling features other than public interest services, such features shall be considered as a basket of services. An increase in the price ceiling for a custom calling feature will be presumed to be reasonable and will be permitted to become effective by the commission if the increase in the sum of the price ceilings of the features in the basket, weighted by the number of subscribers to each custom calling feature, is not greater than twenty percent and the increase for any individual feature is not greater than fifty percent in any twelve-month period beginning February 1 of each year.

(e) If the price ceiling of a non-basic service is proposed to be increased by an amount that is greater than twenty percent in any twelve-month period or if the price ceiling for any individual custom calling feature is proposed to be increased more than fifty percent in any twelve-month period, the commission may take such action as it deems appropriate, including denial or suspension and investigation of the proposed changes in price ceilings.

(3) Price Floors. The price floor for a non-basic service shall be the average cost of providing the service in New Mexico.

(4) Public Interest Services. Notwithstanding the provisions of this rule, a mid-size carrier shall not withdraw the following products and services without express approval of the commission: 911, call trace, caller ID blocking, non-published and non-listed directory services, and discounted services, such as the low income telephone assistance program (LITAP) and lifeline, provided to qualified persons. A mid-size carrier may not increase the price ceiling for 911 services by more than five percent in any twelve-month period without express approval of the commission. A mid-size carrier may not increase the price ceiling for other public interest services by more than ten percent in any twelve-month period without express approval of the commission.

C. Packages.

(1) Authority. A mid-size carrier may offer a combination of basic and non-basic services in a single package as authorized by NMSA 1978 Section 63-9A-5.1(G).

(2) Effective Price. The effective price of a package may be any price that is less than or equal to the price ceiling of the package and greater than or equal to the price floor of the package.

(3) Price Ceilings. The price ceiling for a package shall be less than or equal to the sum of the price ceilings of the components of the package. If the package permits customers to choose elements of the package, the highest such price ceiling shall be calculated assuming the customer chooses the most expensive compatible options.

(4) Price Floors. The price floor for a package shall be the sum of the price floors of the components of the package.

D. Bundles.

(1) Effective Price. The effective price of a bundle may be any price that is less than or equal to the price ceiling of the bundle and greater than or equal to the price floor of the bundle.

(2) Price Ceiling. The initial price ceiling for an existing bundle is the initial price of the bundle. The initial price ceiling for a new bundle is the initial maximum price which shall be less than or equal to the sum of the price ceilings of the regulated services plus the sum of the stand-alone prices of the unregulated services.

(3) Price Floor. The price floor of a bundle is the sum of the price floors of the regulated services plus the cost to the mid-size carrier of acquiring the unregulated services.

E. Prices within Service Areas.

(1) One floor and one ceiling per service. A single price ceiling and a single price floor shall apply to each basic and non-basic service offered by a mid-size carrier in the state.

(2) Prices within and between service areas. A mid-size carrier may charge different prices for basic and non-basic services to customers in different service areas. A mid-size carrier shall charge the same price for a basic or non-basic service to all customers within a service area unless the mid-size carrier demonstrates to the commission that market conditions vary within a service area.

F. Introducing or Withdrawing Non-basic Services, Packages and Bundles.

(1) Commission notice of introductions. Subject to commission suspension under 17.11.23.10 NMAC, a mid-size carrier may offer a new non-basic service, bundle or package by filing a tariff and commission notice no less than ten days prior to the effective date of the tariff.

(2) Commission notice of withdrawals. Subject to commission suspension under 17.11.23.10 NMAC, a mid-size carrier may withdraw any non-basic service, package or bundle from its tariff, except public interest services, by filing a revised tariff and commission notice no less than ten days prior to the effective date of the tariff.

(3) Consumer notice of withdrawals. A mid-size carrier shall notify affected customers of a service to be withdrawn at least ten days before the service is withdrawn.

G. Promotions. A mid-size carrier may offer promotions such as special incentives, discounts, or temporary rate waivers by filing a commission notice not less than three days prior to the effective date of the promotion.

H. Individual Contracts. A mid-size carrier may offer basic and non-basic services on an individual contract basis pursuant to NMSA 1978 Section 63-9A-9 by providing notice to the commission of the individual contract. If the commission does not act within five days of receiving the notice, the individual contract shall be deemed approved by the commission.

[17.11.23.8 NMAC - N, 4-1-2006]

17.11.23.9 TARIFFS, PRICE LISTS AND NOTICE.

A. Tariffs. A mid-size carrier shall maintain a tariff on file with the commission that contains the price ceiling and effective price by service area for each basic service, non-basic service, package and bundle offered by the mid-size carrier.

B. Changes to Terms and Conditions. A mid-size carrier may propose non-price related changes to terms and conditions in its tariffs by filing commission notice and tariff sheets reflecting the modified terms and conditions. Subject to commission suspension under 17.11.23.10 NMAC, the modified terms and conditions of such non-price related changes shall become effective ten days after a mid-size carrier files such commission notice and tariff sheets.

C. Notice of Price Ceiling Changes and Effective Price Changes.

(1) Notice. Subject to commission suspension under 17.11.23.10 NMAC, a mid-size carrier may change the effective price or the price ceiling of a basic service, non-basic service, package or bundle by providing notice as provided in this subsection.

(2) Notice of changes in price ceilings. No less than ten days prior to the effective date of an increase in a price ceiling, the mid-size carrier shall provide notice to the commission and to the New Mexico Attorney General and shall cause notice of the increase to be published in a newspaper with statewide circulation. For decreases to price ceilings, commission notice shall be made no less than one day prior to the effective date of the new price ceiling. No customer notice of decreases in price ceilings is required.

(3) Notice of changes in effective prices. Commission notice of increases in effective price shall be made not less than ten days prior to the effective date of the new price. Commission notice of decreases in effective price shall be made no less than one day prior to the effective date of the new price. Consumer notice of effective price increases shall be made not less than ten days or more than seventy-five days prior to the effective date of the new price. No consumer notice of decreases in effective prices is required.

(4) Website posting of changes in effective price. Each change in effective price shall be reflected on a mid-size carrier's website on or before the date the change becomes effective.

(5) Affidavit Required. Any tariffed change in the effective price or the price ceiling of a basic service, non-basic service, package or bundle must be accompanied by an affidavit, signed by a person with personal knowledge, stating that the effective price is above or equal to the price floor for the service.

(6) Cost Studies. Upon request of the commission or commission staff, a mid-size carrier shall produce a cost study demonstrating how the mid-size carrier calculated the cost of a service.

[17.11.23.9 NMAC - N, 4-1-2006]

17.11.23.10 SUSPENSION: Pursuant to NMSA 1978 Section 63-9A-5.1(G), the commission may suspend a tariff introducing a new service, withdrawing a non-basic service, or changing the effective price or the price ceiling of a basic service or a non-basic service under circumstances limited to ensuring compliance with applicable rules, cost considerations, or a finding that the tariff filing is not consistent with the public interest.

[17.11.23.10 NMAC - N, 4-1-2006]

17.11.23.11 REVIEW AND REPORT TO LEGISLATURE: Two years after the effective date of this rule, the commission and any mid-size carrier shall independently review the provisions of this rule and, subsequently, shall report their findings to the legislature. All or part of such findings may be reported to the legislature either jointly or separately.

[17.11.23.11 NMAC - N, 4-1-2006]

17.11.23.12 WAIVERS: Pursuant to NMSA 1978 Section 63-9A-5.1(H), a mid-size carrier may petition the commission for a waiver of any provision of this rule for good cause shown. Without limitation, extraordinary changes in a carrier's costs caused by administrative, legislative, or judicial action beyond the control of the carrier shall constitute good cause.

[17.11.23.12 NMAC - N, 4-1-2006]

17.11.23.13 ADJUSTMENTS FOR EXOGENOUS COST CHANGES: A mid-size carrier, staff, or other interested party may petition the commission to incorporate exogenous cost changes resulting from extraordinary changes in a mid-size carrier's cost caused by administrative, state or federal legislative changes, or judicial action beyond the control of the mid-size carrier. Such adjustments make take the form of a change in rates, or surcharges or credits on consumers' bills. The commission shall issue a decision on a petition for an exogenous cost adjustment no later than one-hundred and twenty days after the petition is submitted.

[17.11.23.13 NMAC - N, 4-1-2006]

HISTORY OF 17.11.23 NMAC: [RESERVED]

NEW MEXICO PUBLIC REGULATION COMMISSION

TITLE 17 PUBLIC UTILITIES AND UTILITY SERVICE
CHAPTER 11 TELECOMMUNICATIONS
PART 24 QUALITY OF SERVICE STANDARDS APPLICABLE TO MID-SIZE CARRIERS

17.11.24.1 ISSUING AGENCY: New Mexico Public Regulation Commission.

[17.11.24.1 NMAC - N, 4-1-2006]

17.11.24.2 SCOPE: This rule applies to all mid-size carriers.

[17.11.24.2 NMAC - N, 4-1-2006]

17.11.24.3 STATUTORY AUTHORITY: NMSA 1978 Sections 63-9A-5.1 and 63-9A-5.2.

[17.11.24.3 NMAC - N, 4-1-2006]

17.11.24.4 DURATION: Permanent.

[17.11.24.4 NMAC - N, 4-1-2006]

17.11.24.5 EFFECTIVE DATE: April 1, 2006, unless a later date is cited at the end of a section.

[17.11.24.5 NMAC - N, 4-1-2006]

17.11.24.6 OBJECTIVE: The purpose of this rule is to establish quality of service standards applicable to mid-size carriers.

[17.11.24.6 NMAC - N, 4-1-2006]

17.11.24.7 DEFINITIONS: As used in this rule:

A. access line means a dial tone line that provides local exchange service from a mid-size carrier's switching equipment to a point of termination at the customer's network interface;

B. basic services means retail telecommunications services that provide residence or business customers with an individual primary line providing voice grade access to the public switched network;

C. circumstances beyond a mid-size carrier's control are limited to:

(1) failure to obtain necessary rights-of-way or permits despite the filing of timely applications;

(2) extraordinary weather and other acts of God; or

(3) supplier issues, vendor issues, and work stoppages;

D. customer means any person that has applied for or is currently receiving telecommunications services;

E. designed services means the provisioning of end user tariffed circuits requiring special treatment, special equipment, or special engineering design; examples include PBX trunks, rotary lines, DDS, DS-1, DS-3, ISDN-BRI, and special assemblies;

F. designed services held order means an order for designed services where facilities are not available that is not provisioned within forty-five calendar days after the receipt of the customer's order or within forty-five calendar days after the customer's requested service date; an order shall not be considered a held order if the customer was the cause of the delay;

G. held order means an order for a basic service placed by a customer whose premises are within one thousand feet of an existing terminal or pedestal, which, due to a lack of facilities, is not completed within thirty days after the receipt of the order (or within thirty days after the customer's requested service date, where the customer requested a date more than five days after submission of the order); an order shall not be considered a held order if the customer was the cause of the delay;

H. mid-size carrier means any telecommunications company with more than fifty thousand but less than three hundred seventy-five thousand access lines in New Mexico;

I. non-basic services means retail telecommunications services that are not a basic service, a switched access service or a wholesale service governed by an interconnection agreement;

J. out-of-service trouble report is a report from a customer of an inability to receive or place calls on an access line due to lack of dial tone or severe

noise that prevents effective communication;

K. repeat trouble report is a network trouble report on an access line within thirty days of a closed trouble report concerning the same problem on the same line;

L. telecommunications company means a person that provides public telecommunications service;

M. trouble report means notification of trouble or perceived trouble by a customer, third party, or employee acting on behalf of a customer to a mid-size carrier's repair office, including trouble reported on the access lines of the mid-size carrier's retail customers, but not including troubles associated with a customer's unfamiliarity with new features or customer premises equipment, or extraordinary or abnormal conditions of operation.

[17.11.24.7 NMAC - N, 4-1-2006]

17.11.24.8 REPORTING REQUIREMENTS AND SERVICE STANDARDS: For each requirement in this section of the rule, a mid-size carrier shall compile service quality data on a monthly basis by wire center or exchange, as specified, and statewide. A mid-size carrier shall prepare each report of its data for the commission in printed format and in electronic spreadsheet format, listing each wire center or exchange, as specified, alphabetically by name. Within thirty days after the end of each calendar year, a mid-size carrier shall file its service quality report with the commission. Delays caused by customers may be excluded from a mid-size carrier's calculations.

A. Held orders - basic services.

(1) Service standards. A mid-size carrier's annual held order rate for basic services shall not exceed .035%. A mid-size carrier shall notify each customer affected by a held order of the projected service date for that order.

(2) Annual reporting requirements. The annual held order rate shall be the average of the monthly held order rates. The monthly held order rate shall be calculated as the number of a mid-size carrier's held orders for basic service lines as of the last day of the month, excluding orders for which waivers have been granted, expressed as a percentage of the total number of the mid-size carrier's access lines in service at the end of the month. A mid-size carrier shall report annually for each wire center and statewide:

(a) the number of held orders;

(b) the number of total access lines;

(c) the number of held orders expressed as a percent of total access lines;

(d) the number of held orders excluded from the calculations;

(e) the number of held orders pending for more than one hundred eighty days, excluding designed services; and

(f) the number of unfilled orders for designed services pending for more than one hundred eighty days.

(3) Reporting of unfilled orders when construction cannot be completed due to circumstances beyond mid-size carrier's control. Within thirty days of the end of the month in which the mid-size carrier incurs a held order that is not filled because the mid-size carrier must undertake construction of facilities in order to provide the requested service, and such construction cannot be completed in compliance with the held order standard due to circumstances beyond the mid-size carrier's control, the mid-size carrier shall file a report to the commission with the following information:

(a) order number;

(b) wire center;

(c) application date;

(d) requested date of service;

(e) the circumstances beyond the mid-size carrier's control that have caused the order to be delayed;

(f) explanation of what steps the mid-size carrier has taken within the thirty-day period since the order was received to overcome the circumstances beyond the mid-size carrier's control;

(g) the date the customer notification letter was sent;

(h) job number; and

(i) an affidavit from a manager having direct knowledge of the conditions leading to the mid-size carrier being unable to provide service for the orders on the list.

(4) Waivers. Upon the filing of a report pursuant to Paragraph (3) of Subsection A of 17.11.24.8 NMAC, the mid-size carrier is granted a waiver exempting any order that is the subject of a report from the reporting requirements of Paragraph (2) of Subsection A of 17.11.24.8 NMAC. Waivers are granted for up to one year from the report filing date. At the end of the one-year period, the mid-size carrier must remove the order from the waivers list and the order shall be subject to the applicable basic services installation interval standards and reporting requirements.

B. Installation of basic services.

(1) Service standards. A mid-size carrier's annual installation rate for basic services shall be at least ninety-six percent of basic service requests provisioned within five working days of the date such requests were received or by such later dates as requested by customers.

(2) Reporting requirement. A mid-size carrier shall report annually for each exchange and statewide the percent of service requests for basic services that were provisioned within five working days of each service request date or by such later dates as requested by customers. Held orders shall not be included in the calculations.

C. Installation of designed services.

(1) Service standards.

(a) Within three working days of receipt of a customer's request for designed services, a mid-size carrier shall inform the customer whether necessary facilities are available to provision the service.

(b) Where facilities are available, no less than eighty-five percent of service requests for designed services shall be provisioned within fifteen calendar days of the dates such requests were received or by the dates requested by customers, whichever is later.

(c) Where facilities are not available, no less than eighty-five percent of service requests for designed services shall be provisioned within forty-five calendar days of the dates such requests were received or by the dates requested by customers, whichever is later.

(2) Annual reporting requirements. A mid-size carrier shall report annually for each exchange and statewide the percent of requests for designed services provisioned within fifteen working days, where facilities are available, and within forty-five days, where facilities are not available, for each month in the year. The reported percent of requests shall be a twelve-month average percent calculated using twelve months of data in the calendar year. Wholesale orders for designed services and designed services orders involving third parties may be excluded from the calculations.

(3) Reporting of unfilled orders when construction cannot be completed due to circumstances beyond mid-size carrier's control. Within thirty days of the end of the month in which a mid-size carrier incurs a designed services held order that is not filled because the mid-size carrier must undertake construction of facilities in order to provide the requested service, and such construction cannot be completed in compliance with the held order standard due to circumstances beyond the mid-size carrier's control, the mid-size carrier shall file a report to the commission with the following information:

(a) order number;

(b) wire center;

(c) application date;

(d) requested date of service;

(e) the circumstances beyond the mid-size carrier's control that have caused the order to be delayed;

(f) explanation of what steps the mid-size carrier has taken within the forty-five day period since the order was received

to overcome the circumstances beyond the mid-size carrier's control;

(g) the date the customer notification letter was sent;

(h) job number; and

(i) an affidavit from a manager having direct knowledge of the conditions leading to the mid-size carrier being unable to provide service for the orders on the list.

(4) Waivers. Upon the filing of a report pursuant to Paragraph (3) of Subsection C of 17.11.24.8 NMAC, the mid-size carrier is granted a waiver exempting any order that is the subject of a report from the reporting requirements of Paragraph (2) of Subsection C of 17.11.24.8 NMAC. Waivers are granted for up to one year from the report filing date. At the end of the one-year period, the mid-size carrier must remove the order from the waivers list and the order shall be subject to the applicable basic services installation interval standards and reporting requirements.

D. Trouble reports.

(1) Service standard. A mid-size carrier's annual trouble report rate shall not exceed five reports per month per one hundred access lines in service.

(2) Reporting requirements. A mid-size carrier shall report annually for each wire center and statewide the percent of access lines for which trouble reports were received during each month in the year.

E. Out-of-service trouble reports.

(1) Service standard. A mid-size carrier's annual out-of-service rate shall be at least eighty-five percent of out-of-service trouble reports cleared within twenty-four hours.

(2) Reporting requirements. A mid-size carrier shall report annually for each wire center and statewide the number of access lines for which out-of-service trouble reports were received during each month in the year and the percent cleared each month. Out-of-service trouble reports received after 4:00 p.m. Monday through Friday shall be deemed as received at 8:00 a.m. the following business day.

F. Repeat trouble reports.

(1) Service standard. A mid-size carrier's annual repeat trouble report rate shall not exceed eighteen percent of total monthly trouble reports.

(2) Reporting requirements. A mid-size carrier shall report annually for each wire center and statewide the percent of access lines for which repeat trouble reports were received during each month in the year.

[17.11.24.8 NMAC - N, 4-1-2006]

17.11.24.9 OUTAGES:

A. Initial outage report. A mid-size carrier shall report outages lasting longer than one hour and affecting more than one thousand five hundred customers to the consumer relations division of the commission by telephone, facsimile, email, or in person within ninety minutes of the onset of the outage or, for outages not occurring during business hours, at the start of the next business day.

B. Subsequent outage report. A mid-size carrier shall submit a subsequent written report stating the location, duration, number of customers affected, cause and corrective action taken. Both the initial and subsequent outage reports shall state whether 911 circuits were affected.

C. Quarterly outage reports. A mid-size carrier shall file quarterly a record of each outage in the preceding three months for which the mid-size carrier was unable to provide emergency service and an explanation of why emergency service was unavailable.

[17.11.24.9 NMAC - N, 4-1-2006]

17.11.24.10 PROVISION OF SERVICE DURING MAINTENANCE OR EMERGENCIES:

A. Emergency procedures. Each mid-size carrier shall establish and instruct its employees regarding procedures for preventing or mitigating interruption to or impairment of telecommunications service in emergencies resulting from power failures, sudden and prolonged increases in traffic, illness of operators, fire, storm, or acts of God. Mid-size carriers shall file written plans detailing their emergency procedures with the telecommunications bureau of the commission within sixty days after certification by the commission or adoption of this rule, whichever is later. Any changes to the plan shall be filed with the telecommunications bureau of the commission within thirty days of the change.

B. Reserve power requirements. Mid-size carriers shall maintain in each local central office, toll switching office, and tandem switching office a minimum of four hours of battery reserve rated for peak traffic load requirements and shall:

(1) install a permanent auxiliary power unit in toll and tandem switching offices and in central offices serving ten thousand or more access lines; and

(2) have available a mobile power unit which normally can be delivered and connected within four hours for central offices serving fewer than ten thousand access lines.

C. Maintenance scheduling. Mid-size carriers shall schedule maintenance requiring extended service interruptions when it will cause minimal inconvenience to customers and, to the extent possible, shall notify customers in advance of extended service interruptions. Mid-size carriers shall make emergency service available in any area that experiences service interruptions affecting one thousand or more access lines and lasting more than four hours between the hours of 8:00 a.m. and 10:00 p.m. If a mid-size carrier cannot provide emergency service during such a scheduled maintenance period, it shall file a report of the occurrence with the telecommunications bureau of the commission.

D. Loss of switch plan. Each mid-size carrier shall develop a contingency plan to prevent or minimize service interruptions due to the loss of a central office switch that serves more than ten thousand access lines or is the toll or tandem switching office for more than ten thousand access lines. The plan shall describe the actions and systems installed to prevent or minimize the probability of such an occurrence as well as the actions and systems available to minimize the extent of any incurred service interruption. Mid-size carriers shall file the plans with the telecommunications bureau of the commission within sixty days after certification by the commission or after adoption of this rule, whichever is later. Any changes to the plan shall be filed with the telecommunications bureau within thirty days of the change.

[17.11.24.10 NMAC - N, 4-1-2006]

17.11.24.11 ACCESS TO AND AUDIT OF DATA: Unless otherwise authorized by the commission, a mid-size carrier shall make all records required by this rule available to the commission or its authorized representative at any time upon request. A mid-size carrier shall make customer proprietary network information available to the commission to the extent allowed by law. A mid-size carrier shall retain records of reports, measurements, summaries, and backup information for at least two years. A mid-size carrier's service quality data shall be subject to periodic audit by the commission.

[17.11.24.11 NMAC - N, 4-1-2006]

17.11.24.12 LINE EXTENSION: Each mid-size carrier shall file, pursuant to 17.11.24.16 NMAC, a tariff describing its line extension policy and any subsequent modifications to its line extension policy.

[17.11.24.12 NMAC - N, 4-1-2006]

17.11.24.13 TIMELY RESPONSE BY CUSTOMER SERVICE REPRESENTATIVES:

A. Service standards. A mid-size carrier's business offices and repair centers shall answer ninety percent of calls within twenty seconds. If a carrier uses an automatic response system, the sys-

tem shall answer ninety-five percent of calls within fifteen seconds of the customer's selection or within forty seconds if the customer does not make a selection. A mid-size carrier shall ensure that no more than one percent of calls to its business offices reach a busy signal and that no more than one percent of calls to its repair centers reach a busy signal.

B. Reporting requirement. A mid-size carrier shall file an exception report within twenty-one calendar days of the end of any month in which it failed to meet any of the standards set forth in 17.11.24.13(A) NMAC. The report shall identify each offending repair center or business office, the percent of calls answered, the percent of calls reaching a busy signal, the reason for failure to meet the respective standard, the remedial action taken by the mid-size carrier, and any known results of that remedial action.
[17.11.24.13 NMAC - N, 4-1-2006]

17.11.24.14 DIRECTORY ASSISTANCE AND INTERCEPT:

A. Service standard. A mid-size carrier shall list basic service customers (except those customers requesting otherwise) in the directory assistance database within twenty-four hours of service connection, except during times of regular maintenance, in which case the listing shall occur within forty-eight hours of service connection.

B. Errors in listing. If a mid-size carrier makes an error in the listed number or name of any customer, then until a new directory is published, the mid-size carrier shall make, at no charge to the customer, whatever special arrangements are necessary and reasonable to ensure that calling parties are able to reach the customer whose listed number or name is in error. If a mid-size carrier makes an error in the listed number, name or address of any customer, the mid-size carrier shall place the customer's correct name, address and telephone number in the files of the directory assistance and intercept operators within seventy-two hours of confirmation of the error.

C. Intercept service. When a customer's telephone number is changed at the request of the customer after a directory is published, the mid-size carrier shall provide intercept service for all calls to the former number for the lesser of sixty days or until a new directory is issued. If the change is made at the initiative of the mid-size carrier, the mid-size carrier shall provide intercept service for the former number at no charge to the customer for the greater of sixty days or the remaining life of the current directory. The mid-size carrier shall provide the correct number to its information operator within twenty-four hours of the number change (except during times of regular maintenance, in which case the listing shall occur within forty-eight hours of service connection) or send it to the carrier providing information operator service within twenty-four hours if the local exchange carrier does not provide its own service. The mid-size carrier intercept recording shall state how the caller can obtain the new number.
[17.11.24.14 NMAC - N, 4-1-2006]

17.11.24.15 WAIVERS: Pursuant to NMSA 1978 Section 63-9A-5.1(H), a mid-size carrier may petition the commission for a waiver of this rule for good cause shown.
[17.11.24.15 NMAC - N, 4-1-2006]

17.11.24.16 TARIFFS: A mid-size carrier may propose changes to terms and conditions in its tariffs related to this rule by filing with the commission a notice and tariff sheets reflecting the modified terms and conditions. The modified terms and conditions shall become effective ten days after a mid-size carrier files such commission notice and tariff sheets, unless the commission suspends the mid-size carrier's proposed tariffs.
[17.11.24.16 NMAC - N, 4-1-2006]

17.11.24.17 REVIEW AND REPORT TO LEGISLATURE: Two years after the effective date of this rule, the commission and any mid-size carrier shall independently review the provisions of this rule and, subsequently, shall report their findings to the legislature. All or part of such findings may be reported to the legislature either jointly or separately.
[17.11.24.17 NMAC - N, 4-1-2006]

HISTORY OF 17.11.24 NMAC: [RESERVED]

NEW MEXICO PUBLIC REGULATION COMMISSION

TITLE 17 PUBLIC UTILITIES AND UTILITY SERVICES
CHAPTER 11 TELECOMMUNICATIONS
PART 25 CONSUMER PROTECTION STANDARDS APPLICABLE TO MID-SIZE CARRIERS

17.11.25.1 ISSUING AGENCY: New Mexico Public Regulation Commission.
[17.11.25.1 NMAC - N, 4-1-2006]

17.11.25.2 SCOPE: This rule applies to all mid-size carriers.
[17.11.25.2 NMAC - N, 4-1-2006]

17.11.25.3 STATUTORY AUTHORITY: NMSA 1978 Section 63-9A-5.1(F)(1).
[17.11.25.3 NMAC - N, 4-1-2006]

17.11.25.4 DURATION: Permanent.
[17.11.25.4 NMAC - N, 4-1-2006]

17.11.25.5 EFFECTIVE DATE: April 1, 2006, unless a later date is cited at the end of a section.
[17.11.25.5 NMAC - N, 4-1-2006]

17.11.25.6 OBJECTIVE: The purpose of this rule is to establish consumer protection standards applicable to mid-size carriers.
[17.11.25.6 NMAC - N, 4-1-2006]

17.11.25.7 DEFINITIONS: As used in this rule:

A. access line means a dial tone line that provides local exchange service from a mid-size carrier's switching equipment to a point of termination at the customer's network interface;

B. basic local exchange service means the customer's voice grade access to the public switched network, dual tone multifrequency (DTMF) signaling or its functional equivalent, and access to emergency services (911 and E-911), operator services, toll services, directory assistance, and toll blocking services for qualifying low income customers, but does not include discretionary services;

C. consumer means any person that has applied for or is currently receiving telecommunications services, either residential or business;

D. discretionary service means voice mail, caller ID, caller name ID, call waiting, three-way calling, call forwarding, call return, call blocker, auto redial, and any similar service sold as an add-on to a consumer's basic local exchange service;

E. LITAP means the low income telephone assistance program;

F. mid-size carrier means a telecommunications company with more than fifty thousand but less than three hundred seventy-five thousand access lines in the state;

G. primary line means the first exchange access line installed by a mid-size carrier to serve a consumer at the consumer's premise, as distinct from additional lines that may be ordered at the same time or subsequently;

H. telecommunications company means a person that provides public telecommunications service;

I. wire center means a facility where local exchange access lines converge and are connected to a switching

device which provides access to the public switched network, and includes remote switching units and host switching units.
[17.11.25.7 NMAC - N, 4-1-2006]

17.11.25.8 DISCONNECTION OF BASIC LOCAL EXCHANGE SERVICE AND ALLOCATION OF PARTIAL PAYMENTS:

A. Failure to pay. A mid-size carrier shall not disconnect a consumer's basic local exchange service for failure to pay charges for toll or discretionary services.

B. Toll blocking offer. A mid-size carrier shall offer toll blocking upon a consumer's request.

C. Involuntary toll blocking. A mid-size carrier may impose involuntary toll blocking on a consumer's primary line for failure to pay charges for toll service. However, the toll blocking must be provided without charge and the mid-size carrier must remove the toll blocking when the bill is paid.

D. Partial payments. A consumer's partial payments for current bills or past due amounts shall be credited first to basic local exchange service unless the consumer instructs the mid-size carrier in writing to allocate the payment in a different manner.
[17.11.25.8 NMAC - N, 4-1-2006]

17.11.25.9 ACCESS TO AND AUDIT OF DATA: Unless otherwise authorized by the commission, a mid-size carrier shall make all records required by this rule available to the commission or its authorized representatives at any time upon reasonable notice. A mid-size carrier shall make consumer proprietary network information available to the commission to the extent allowed by law. A mid-size carrier shall retain all records required by this rule for at least two years. The timeliness, accuracy, and courteousness of mid-size carriers' consumer service and repair bureau representatives shall be subject to periodic audit by the commission.
[17.11.25.9 NMAC - N, 4-1-2006]

17.11.25.10 CONSUMER COMPLAINT TRACKING:

A. Records maintained. A mid-size carrier shall maintain a record of all oral and written complaints, including informally resolved billing disputes, made by or on behalf of consumers which shall contain:

(1) the name and address of the consumer or complainant;

(2) the date the complaint is lodged;

(3) the class of consumer (residence or business);

(4) the category (i.e., nature) of the complaint;

(5) the resolution of the complaint; and

(6) the date the complaint is resolved.

B. Consumer relations. A mid-size carrier shall not retaliate against a consumer for any complaint made by the consumer to the commission or any other person.

C. Commission report. Upon request of the commission or staff, a mid-size carrier shall compile and submit to the commission reports that state the total number of complaints received during a specified period not to exceed two years and the number of such complaints categorized by the:

(1) category of the complaint;

(2) region within the state (e.g., by wire center, exchange, county); and

(3) class of consumer (residential or business).

D. Resolving complaints. A mid-size carrier shall cooperate with the commission and the commission's consumer relations division and staff in resolving complaints.
[17.11.25.10 NMAC - N, 4-1-2006]

17.11.25.11 ACCESS TO PRODUCT AND PRICING INFORMATION; ADHERENCE TO FAIR MARKETING PRACTICES:

A. Product and pricing information. A mid-size carrier shall make product and pricing information available to consumers upon request. When a consumer initially subscribes to basic local exchange service, a mid-size carrier shall provide information about LITAP, including a toll-free number the consumer can call to obtain further information about LITAP and the requirements for eligibility.

B. Fair marketing. A mid-size carrier shall adhere to all applicable state and federal laws and regulations governing fair marketing of telecommunications services.
[17.11.25.11 NMAC - N, 4-1-2006]

17.11.25.12 TARIFFS AND BOUNDARY MAPS:

A. Tariffs. Upon certification by the commission to provide services in the state, a mid-size carrier shall file tariffs which specifically set forth:

(1) rates, charges, terms, and conditions for all intrastate services;

(2) conditions and circumstances under which the mid-size carrier, or entities under contract to the mid-size carrier, will make special construction available to applicants within the exchange area;

(3) minimum standards for discontinuance of residential basic local exchange service consistent with 17.11.25.16 NMAC; and

(4) charges for service connections, extensions and line mileage.

B. Public access to tariffs and price lists. A mid-size carrier shall post tariffs and price lists on its website and shall, upon request, make copies of tariffs and price lists available for review by the public.

C. Boundary maps. Upon certification by the commission, each mid-size carrier shall file an exchange area boundary map for each of its exchanges in New Mexico. Each map shall clearly show the boundary lines of the exchange area the mid-size carrier holds itself out as serving. Where a portion of the boundary line is not located on section lines, waterways, railroads, etc, the exchange boundary lines shall be located by appropriate measurement to an identifiable location. Maps generally shall contain the detail shown on county highway maps. Each map shall be to a scale and in sufficient detail to permit a person to locate the exchange service area boundaries.
[17.11.25.12 NMAC - N, 4-1-2006]

17.11.25.13 BILLS: A mid-size carrier shall provide easily readable, readily understandable bills.

A. Itemization. A mid-size carrier's bills shall itemize services, usage, and charges, including quantities of units and per-unit charges.

B. Nonrecurring and recurring charges. A mid-size carrier's bills shall separately identify nonrecurring and recurring charges.

C. Toll-free access to mid-size carrier. A mid-size carrier's bills shall include the name and toll-free number of the mid-size carrier.

D. Right to dispute statement. A mid-size carrier's bills shall include a statement, in English and Spanish, advising consumers that they have a right to dispute the bill.

E. Toll-free access to commission. A mid-size carrier's bills shall include the toll-free number of the consumer relations division of the commission.
[17.11.25.13 NMAC - N, 4-1-2006]

17.11.25.14 INFORMATION REQUIRED SEMI-ANNUALLY:

A. Information provided in English and Spanish. A mid-size carrier shall semi-annually provide information to consumers in English and Spanish. A mid-size carrier need not provide all of the information at the same time and may choose to provide it in a prominent place on a consumer's bill or in a bill insert. The follow-

ing information is required:

(1) a statement that basic local exchange service will not be discontinued to any residence where a seriously ill or chronically ill person resides if the person responsible for the telephone service charges does not have the financial resources to pay the charges and if a licensed physician, physician's assistant, osteopathic physician, osteopathic physician's assistant or certified nurse practitioner certifies that discontinuance of service might endanger that person's health or life and the certificate is delivered to a manager or officer of the mid-size carrier at least two days prior to the due date of a bill for telephone service;

(2) a statement, using commonly understood descriptions and examples, that basic local exchange service will not be discontinued for failure to pay charges for toll or discretionary services;

(3) notification that service and rate information is available in telephone directories, on the mid-size carrier's web site, by calling a toll-free telephone number, or in other written materials such as brochures which the mid-size carrier shall provide upon request; and

(4) a brief description of LITAP, a toll-free number the consumer can call to obtain further information about LITAP, and the name and telephone number of the human services department (HSD) employee designated to determine eligibility for LITAP.

B. Information regarding consumer calling patterns. A mid-size carrier shall semi-annually notify consumers that they have the right to request that the mid-size carrier not disclose to any person, other than to employees of the mid-size carrier who have a need for the information in the course of providing telecommunications services, information about the consumer, including the consumer's calling patterns.

[17.11.25.14 NMAC - N, 4-1-2006]

17.11.25.15 BILLING DISPUTES, OVERBILLINGS AND UNDERBILLINGS:

A. Billing disputes. In the event of a dispute between a consumer and a mid-size carrier concerning a bill for intrastate telecommunications services, the mid-size carrier may require the consumer to pay the undisputed portion of the bill to avoid discontinuance of service for nonpayment. The mid-size carrier shall make an investigation appropriate to the case, and report the results to the consumer. In the event the dispute is not reconciled, the mid-size carrier shall advise the consumer that the consumer may file a complaint with the commission for disposition of the matter.

B. Overbilling and underbilling. Whenever the billing for service has not been determined accurately because of a mid-size carrier's omission or negligence, the mid-size carrier shall offer and enter into reasonable payment arrangements in accordance with the following criteria:

(1) When a mid-size carrier has overbilled a consumer for service and the consumer has paid the overbilled amount, the mid-size carrier shall credit the total overbilled amount within a reasonable time, but in no event later than the second bill after the mid-size carrier becomes aware of the error.

(2) Whenever a mid-size carrier has underbilled a consumer for service, the mid-size carrier may add the underbilled amount to the consumer's next regular bill, unless the amount exceeds the consumer's average bill for the preceding six months, in which case the consumer may elect to make payments, without interest, over a time period equal to the period over which the errors were accumulated.

[17.11.25.15 NMAC - N, 4-1-2006]

17.11.25.16 DISCONTINUANCE OR INTERRUPTION OF SERVICE:

A. Discontinuance without prior notice. A mid-size carrier may discontinue basic local exchange service to a consumer without prior notice in the event of:

(1) a condition determined by the mid-size carrier to be hazardous;

(2) a consumer's use of equipment in such manner as to adversely affect the mid-size carrier's equipment or service to others;

(3) a consumer's tampering with, damaging, or deliberately destroying equipment furnished and owned by the mid-size carrier; or

(4) unauthorized use of service provided by the mid-size carrier.

B. Discontinuance with prior notice. Pursuant to 17.11.25.17 and 17.11.25.18 NMAC, a mid-size carrier may discontinue basic local exchange service to a consumer with prior notice:

(1) for nonpayment of a delinquent account; or

(2) for failure to post a security deposit or guarantee.

C. Temporary interruption without notice. A mid-size carrier may temporarily and without notice interrupt service for an operational emergency, necessary and unavoidable network maintenance, or reasons related to the public safety and welfare.

[17.11.25.16 NMAC - N, 4-1-2006]

17.11.25.17 PROHIBITIONS ON DISCONTINUANCE OF SERVICE: A mid-size carrier shall not discontinue basic local exchange service for the reasons listed in this section.

A. Persons who are ill. A mid-size carrier shall not discontinue basic local exchange service to any residence where a seriously ill or chronically ill person resides, if the person responsible for the telecommunications service charges does not have the financial resources to pay the charges and a licensed physician, physician assistant, osteopathic physician, osteopathic physician's assistant or certified nurse practitioner certifies that discontinuance of service might endanger that person's health and the certificate is delivered to a manager or officer of the mid-size carrier at least two days prior to the date scheduled for discontinuance of service.

B. Nonpayment. A mid-size carrier shall not discontinue basic local exchange service for nonpayment of:

(1) the disputed portion of a bill;

(2) amounts billed for discretionary services.

C. Previous occupant. A mid-size carrier shall not discontinue basic local exchange service for a delinquency in payment for service to a previous occupant of the same premises unless the previous occupant continues to reside at the premises or the new customer is legally liable for the debt of the previous occupant.

D. Estimated bills. A mid-size carrier shall not discontinue basic local exchange service for failure of a consumer to pay an estimated bill rendered in violation of applicable commission rules.

[17.11.25.17 NMAC - N, 4-1-2006]

17.11.25.18 REQUIREMENTS PRIOR TO DISCONTINUANCE OF SERVICE:

A. Written notice required. At least fifteen days before a mid-size carrier discontinues service to a consumer, the mid-size carrier shall hand-deliver or mail written notice to the consumer of its intent to discontinue service. The notice shall be in English and Spanish, and shall be in simple language. The notice shall be hand-delivered or sent by U.S. Mail, postage prepaid, to the last address for the consumer known to the mid-size carrier.

B. Contents of written notice. A notice of discontinuance shall contain:

(1) the name, title, address, telephone number, and working hours of mid-size carrier personnel responsible for administering the procedures in this section;

(2) the amount owed and the specific date service shall be discontinued unless the consumer pays the amount due or makes other arrangements with the mid-size carrier concerning payment of the charges. Upon request, the mid-size carrier shall provide information to the consumer concerning the outstanding charges, including the dates of the service interval over which the outstanding charges were incurred and the

date and amount of the last payment;

(3) a statement that if the consumer pays the portion of the bill which the consumer does not dispute, the mid-size carrier shall review the portion of the bill which the consumer does dispute;

(4) a statement that a consumer may file a complaint with the commission if the consumer disagrees with the mid-size carrier's determination concerning discontinuance of service;

(5) statement that basic local exchange service shall not be discontinued to a residence where a seriously ill or chronically ill person resides if the person responsible for the telecommunications service charges does not have the financial resources to pay the charges and a licensed physician, physician assistant, osteopathic physician, osteopathic physician's assistant or certified nurse practitioner certifies that discontinuance of service might endanger that person's health and the certificate is delivered to a manager or officer of the mid-size carrier at least two days prior to the date scheduled for discontinuance of service; and a statement that if service has been discontinued a mid-size carrier shall re-establish service within twelve hours of receipt of the certificate;

(6) a form for certifying that a consumer is eligible to continue service pursuant to NMSA 1978 Section 63-9A-8.3 and a form for certifying that a consumer does not have the financial resources to pay the charges;

(7) a statement in capital letters of the cost of reconnection; and

(8) the following statement in capital letters, "If you have difficulty paying this bill, and feel you may qualify for assistance in paying your telecommunications bills, contact [name and telephone number of HSD employee] to find out if you are eligible for the low income telephone assistance program (LITAP)."

C. Payment plans.

(1) A mid-size carrier shall attempt to arrange a plan for the payment of past due mid-size carrier charges when a residential consumer who has not been chronically delinquent indicates an inability to pay the charges. The mid-size carrier shall not discontinue service to the residential consumer while a payment plan is being negotiated. The mid-size carrier shall also maintain a list of organizations in the area that may provide assistance to consumers in paying telecommunications bills and shall make application forms for LITAP available upon request.

(2) Each mid-size carrier shall provide a procedure for reviewing residential consumer allegations that a proposed payment plan is unreasonable, that a mid-size carrier charge is not due and owing, or that it has not violated an existing payment plan. A mid-size carrier shall not discontinue service until the review is completed.

[17.11.25.18 NMAC - N, 4-1-2006]

17.11.25.19 RESTORATION OF SERVICE:

A. Restoration after payment of charges. A mid-size carrier shall promptly restore service within two business days after payment of all past-due charges, including in part any required deposit and a charge for restoration of service, if any.

B. Restoration for persons who are ill. A mid-size carrier shall restore service to a residential consumer within twelve hours of receipt of a medical certificate and a form certifying that the consumer does not have the financial resources to pay the charges.

[17.11.25.19 NMAC - N, 4-1-2006]

17.11.25.20 COMPLAINTS AND APPEALS:

A. Responding to complaints from consumers. A mid-size carrier shall fully and promptly investigate and respond to all oral and written complaints made directly to the mid-size carrier by applicants or consumers. The mid-size carrier shall make a good faith attempt to resolve the complaint and shall notify the consumer promptly of its proposed disposition of the complaint. Upon request, the mid-size carrier shall send written confirmation of its proposed disposition of the complaint to the consumer.

B. Escalation of complaints. If a mid-size carrier's consumer representative cannot resolve a complaint to a consumer's satisfaction, the consumer representative shall offer to refer the consumer to a supervisor for further consideration. If the consumer still expresses dissatisfaction after attempting to resolve the matter with the supervisor, the mid-size carrier shall provide the complainant with the name, address and current local or toll-free telephone number of the consumer relations division of the commission.

C. Responding to consumer complaints via the commission. Upon receipt of an oral or written complaint from the commission on behalf of a consumer or applicant, a mid-size carrier shall make a suitable investigation. A mid-size carrier shall provide an initial oral or written response to the commission within ten business days after the mid-size carrier receives the complaint. Upon resolution of the complaint, a mid-size carrier shall provide a written response to the commission detailing the mid-size carrier's disposition of the complaint.

[17.11.25.20 NMAC - N, 4-1-2006]

17.11.25.21 WAIVERS: Pursuant to NMSA 1978 Section 63-9A-5.1(H), a mid-size carrier may petition the commission for a waiver of a rule for good cause shown.

[17.11.25.21 NMAC - N, 4-1-2006]

17.11.25.22 REVIEW AND REPORT TO LEGISLATURE: Two years after the effective date of this rule, the commission and any mid-size carrier shall independently review the provisions of this rule and, subsequently, shall report their findings to the Legislature. All or part of such findings may be reported to the Legislature either jointly or separately.

[17.11.25.22 NMAC - N, 4-1-2006]

17.11.25.23 TARIFFS: A mid-size carrier may propose changes to terms and conditions in its tariffs related to this rule by filing with the commission a notice and tariff sheets reflecting the modified terms and conditions. The modified terms and conditions shall become effective ten days after a mid-size carrier files such commission notice and tariff sheets unless the commission suspends the mid-size carrier's proposed tariffs.

[17.11.25.23 NMAC - N, 4-1-2006]

17.11.25.24 INITIAL TROUBLE ISOLATION: If a consumer reports trouble on a line, a mid-size carrier shall, without charge to the consumer and by use of whatever means necessary, determine whether the trouble is on the mid-size carrier or consumer side of the network interface.

[17.11.25.24 NMAC - N, 4-1-2006]

HISTORY OF 17.11.25 NMAC: [RESERVED]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

This is an amendment to 13 8.2 NMAC, Sections 1, 2, 3, 5, 7, 8, 9, 10, 11, 14, 17, 18, 20, 21, 22, 25 and 26, effective March 1, 2006.

13.8.2.1 ISSUING AGENCY: New Mexico Public Regulation Commission Insurance Division [~~, Post Office Box 1269, Santa Fe, NM 87504-1269~~].

[7-1-97; 13.8.2.1 NMAC - Rn & A, 13 NMAC 8.2.1, 1-15-02; A, 3-1-06]

13.8.2.2 SCOPE: This rule applies to all rate and rate-related rules filings made on or after the effective date of

this rule pursuant to Chapter 59A, Article 17 NMSA 1978, including but not limited to rate filings applicable to risks covered through assigned risk pools and similar residual market plans.
[7-1-97; 13.8.2.2 NMAC - Rn & A, 13 NMAC 8.2.2, 1-15-02; A, 3-1-06]

13.8.2.3 S T A T U T O R Y AUTHORITY: Sections 59A-2-9, 59A-17-2, 59A-17-3, 59A-17-4, 59A-17-5, 59A-17-16, 59A-17-17, 59A-17-28, 59A-17-29 and 59A-32-13 NMSA 1978.
[7-1-97; 13.8.2.3 NMAC - Rn & A, 13 NMAC 8.2.3, 1-15-02; A, 3-1-06]

13.8.2.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section [~~or paragraph~~].
[7-1-97; 13.8.2.5 NMAC - Rn, 13 NMAC 8.2.5, 1-15-02; A, 3-1-06]

13.8.2.7 DEFINITIONS: [~~As used in this rule:~~]

A. Advisory filing means any filing by a licensed rate service organization within the scope of its license, solely for informational purposes and such limited uses as provided in 13.8.2.20 NMAC. The term includes a rate filing limited to pure premium rates, supplementary rates, and supporting data developed and trended as appropriate.

B. Credible or **credibility** in connection with statistical data is used in conformance with generally-accepted actuarial standards.

C. Commercial insurance means property or casualty insurance that is within the scope of Chapter 59A, Article 17 NMSA 1978 where the insured is a business, government entity or non-profit organization.

[~~C~~]D. Expenses include acquisition expenses, field supervision and collection expenses, general expenses, taxes, licenses and fees.

[~~D~~]E. Filing means any submission to the superintendent to establish or revise rates.

[~~E~~]F. Line of business means a line of business as shown in the annual statement to the superintendent.

[~~F~~]G. Pure premium rate means that portion of a rate which represents the loss cost per unit of exposure, and may include loss adjustment expense.

[~~G~~]H. Regular business day means every day except Saturday, Sunday and official state government holidays.

[~~H~~]I. Regular business hours are 8:00 a.m. to 5:00 p.m., mountain standard or mountain daylight time, whichever is applicable, on regular business days; provided that regular business hours may be shortened on certain days without notice by official action of the governor or the public regulation commission.

[~~I~~]J. Rate service organization has the meaning given in Section 59A-17-4 NMSA 1978.

[~~J~~]K. Supplementary rate information has the meaning given in Section 59A-17-4 NMSA 1978.

[~~K~~]L. Supporting data means data and information which justifies, supports, interprets, describes, explains or underlies any rate or supplementary rate information, including but not limited to data the superintendent requires or may require pursuant to this rule.
[7-1-97; 13.8.2.7 NMAC - Rn & A, 13 NMAC 8.2.7, 1-15-02; A, 3-1-06]

13.8.2.8 FILING PROCEDURES:

[~~A. Every filing shall be made by submitting it to the Superintendent in accordance with this section.~~

~~(1) Filings may be made by mail, courier or in person and shall be addressed to the Superintendent.~~

~~(2) Filings shall be submitted in an original and one copy, along with a self-addressed stamped envelope. All filings shall be submitted with a completed cover sheet in substantially the format of the cover sheet attached hereto as Form A.~~

~~(3) If a filer desires acknowledgment of receipt, a suitable receipt shall be submitted together with a second self-addressed, stamped envelope. Such receipts are returned as a courtesy and accommodation to the filer. Failure to return a receipt, even though requested in accordance with this subpart, shall not stay, toll, extend or otherwise affect any time period, or limit or otherwise affect any action the Superintendent may take.~~

~~(4) Filings shall be date stamped as of the date received. Each filing shall be reviewed upon receipt for compliance with procedural requirements. If found to comply, the filing shall be accepted as of the date received. If found not to comply, the filing shall be returned to the filer or the filer shall be otherwise notified.~~

~~(5) Filings not received during regular business hours on a regular business day shall be deemed received on the next regular business day.~~

~~B. In computing periods of time, the last day shall be counted and the first day shall not be counted. Saturdays, Sundays and holidays shall be counted. If the last day of a time period falls on a day which is not a regular business day, the time period shall be extended to the close of business on the next regular business day.~~

~~C. Every filing shall be open to public inspection during regular business hours. A copy of any filing or a designated portion thereof may be obtained by making request to the Superintendent and paying the charge he shall prescribe.~~

~~D. Every filing shall remain on file for the statutory review period before it becomes effective, even though the Superintendent has earlier approved it.~~

~~E. Any filing may be withdrawn at any time prior to the time it becomes effective. In the interest of efficiency, filers should notify the Superintendent of withdrawals at the earliest possible date~~.]

A. Every filing shall be made by submitting it to the superintendent in accordance with 13.8.2.8 NMAC.

B. Filings shall be made separately from policy form filings.

C. Filings may be made by mail, courier, the national association of insurance commissioners' system for electronic rate and forms filing (SERFF) or in person and shall be addressed to the superintendent.

D. Paper filings shall be submitted in an original and one copy, along with a self-addressed stamped envelope.

E. All filings shall be submitted with the appropriate current completed transmittal documents in substantially the format of the national association of insurance commissioners' uniform transmittal documents, which are available online at www.naic.org.

(1) The *property and casualty transmittal* document shall include:

(a) group name and "NAIC" number;

(b) company name, domicile, "NAIC" number and "FEIN" number;

(c) company tracking number;

(d) contact information of filer or corporate officer, including: name and address; title; telephone numbers; fax numbers and e-mail address;

(e) signature and printed name of authorized filer;

(f) type and sub-type of insurance;

(g) state specific product code, if applicable;

(h) company program title;

(i) filing type;

(j) effective date requested, including: new or renewal;

(k) a statement indicating whether the filing is a reference filing, including the reference organization name and reference organization number and title, if applicable;

(l) company's date of filing;

(m) status of filing in domicile;

(n) company tracking number;

(o) filing description; and

(p) the appropriate filing fees, including check number and fee amount, if applicable.

(2) The *rate/rule filing schedule* document shall include:

(a) company tracking number;

(b) corresponding company tracking number of form filing, if applicable;

(c) a statement indicating whether the filing is for a rate increase or rate decrease or is rate neutral;

(d) a description of the filing method;

(e) a description of the rate change proposed by the company, including: company name, overall percentage rate impact; written premium change for the program; number of policyholders affected for the program; written premium for the program; and maximum percentage change;

(f) overall percentage of last rate revision;

(g) effective date of last rate revision;

(h) a description of the filing method of the company's last filing; and

(i) a statement of the rule number or page number submitted for review, including whether the filing is new, a replacement or a withdrawal and the previous state filing number.

F. If the filing includes a loss cost multiplier, the filer shall also submit the appropriate current completed national association of insurance commissioners' loss cost transmittal documents which are available online at www.naic.org.

(1) The *lost cost data entry* document shall include:

(a) company tracking number;

(b) name of advisory organization and reference or item filing number if the filing is an adoption of an advisory organization loss cost filing;

(c) company name and "NAIC" number;

(d) product coding matrix for line of business (type of insurance) and line of insurance (sub-type of insurance);

(e) a statement describing coverage, indicated percentage rate level change, requested percentage rate level change, and for loss costs only: expected loss ratio; loss cost modification factor; selected loss cost multiplier; expense constant, if applicable; and company current loss cost multiplier;

(f) a five year rate change history, including: year; policy count; percentage of change; effective date; state earned premium; incurred losses, state loss ratio and countrywide loss ratio;

(g) a statement of selected provisions for expense constants, including: total production expense; general expense; taxes, license and fees; underwriting profit and contingencies; other expenses; and the total of all figures listed;

(h) a statement of whether the company will apply lost cost factors to future filings; and

(i) a statement of the estimated maximum rate increase for any insured.

(2) The *expense constant supplement* document shall include:

(a) company tracking number;

(b) corresponding company tracking number of form filing, if applicable;

(c) a description of development of expected loss ratio;

(d) a statement of selected overall, variable, and fixed provisions for total production expense; general expense; taxes, license and fees; underwriting profit and contingencies; other expenses; and the total of all figures listed;

(e) a statement of the expected loss ratio and the variable expected loss ratio;

(f) a statement of the formula expense constant and the formula variable loss cost multiplier;

(g) a statement of the selected expense constant and the selected variable loss cost multiplier;

(h) an explanation of any differences between Subparagraphs (f) and (g) of Paragraph (2) of Subsection F of 13.8.2.8 NMAC; and

(i) a statement of the rate level change for the coverage to which the *expense constant supplement* document applies.

(3) The *loss cost filing for other than workers' compensation* document shall include:

(a) company tracking number;

(b) corresponding company tracking number of form filing, if applicable;

(c) loss cost reference filing number or a statement that the filing is an independent rate filing;

(d) a statement that:

(i) the insurer files to have its loss cost multipliers and, if utilized, expense constants be applicable to future revisions of the advisory organization's prospective loss costs for this line of insurance; the insurer's rates will be the combination of the advisory organization's prospective loss costs and the insurer's loss cost multipliers and if utilized, expense constants specified in the attachments; the rates will apply to policies written on or after the effective date of the advisory organization's prospective loss costs; this authorization is effective until disapproved by the commissioner, or until amended or withdrawn by the insurer; or

(ii) the insurer files to have its loss cost multipliers and, if utilized, expense constants be applicable only to the identified advisory organization reference filing;

(e) a statement of the line, sub line, coverage, territory, class or combination thereof to which the *loss cost filing* document applies;

(f) a description of loss cost modification;

(g) if expense constants are utilized, the filer shall attach *expense constant supplement* or other supporting information and shall not include the items listed in Subparagraphs (h) through (l) of Paragraph (3) of Subsection F of 13.8.2.8 NMAC;

(h) a description of development of expected loss ratio, including selected provisions for:

(i) total production expense;

(ii) general expense;

(iii) taxes, licenses and fees;

(iv) underwriting profit and contingencies;

(v) other expense, and

(vi) total of all figures listed;

(i) a statement of expected loss ratio;

(j) a statement of the company formula loss cost multiplier;

(k) a statement of the company selected loss cost multiplier; and

(l) a statement of the rate level change for the coverage(s) to which the *loss cost filing* document applies.

(4) The *loss cost filing for workers' compensation* document shall include:

(a) company tracking number;

(b) corresponding form filing number;

(c) loss cost reference filing number or a statement that the filing is an independent rate filing;

(d) a statement that:

(i) the insurer files to have its loss cost multipliers and, if utilized, expense constants be applicable to future revisions of the advisory organization's prospective loss costs for this line of insurance; the insurer's rates will be the combination of the advisory organization's prospective loss costs and the insurer's loss cost multipliers and if utilized, expense constants specified in the attachments; the rates will apply to policies written on or after the effective date of the advisory organization's prospective loss costs; this authorization is effective until disapproved by the commissioner, or until amended or withdrawn by the insurer; or

(ii) the insurer files to have its loss cost multipliers and, if utilized, expense constants be applicable only to the identified advisory organization reference filing;

(e) applicable class codes;

(f) description of loss cost modification;

(g) if expense constants are utilized, the filer shall attach *expense constant supplement* or other supporting information and shall not include the items listed in Subparagraphs (h) through (o) of Paragraph (4) of Subsection F of 13.8.2.8 NMAC;

(h) a description of development of expected loss and loss adjustment expense ratio, including selected provisions for:

(i) total production expense;

(ii) general expense;

(iii) taxes, licenses and fees;

(iv) underwriting profit and contingencies;

(v) other expenses, and

(vi) total of all figures listed;

(i) a statement of expected loss ratio;

(j) a statement of the overall impact of expense constant and minimum premiums;

(k) a statement of the overall impact of size-of-risk discounts plus expense graduation recognition in retrospective rating;

(l) a statement of the company formula loss cost multiplier;

(m) a statement of the company selected loss cost multiplier;

(n) a statement disclosing whether the filer is amending its minimum premium formula; and

(o) a statement disclosing whether the filer is changing its premium discount schedules.

(5) If a filer desires acknowledgment of receipt, a suitable receipt shall be submitted together with a second self-addressed, stamped envelope. Such receipts are returned as a courtesy and accommodation to the filer. Failure to return a receipt, even though requested in accordance with Paragraph (5) of Subsection A of 13.8.2.8 NMAC, shall not stay, toll, extend or otherwise affect any time period, or limit or otherwise affect any action the superintendent may take.

(6) Filings shall be date stamped as of the date received. Each filing shall be reviewed upon receipt for compliance with procedural requirements. If found to comply, the filing shall be accepted as of the date received. If found not to comply, the filing shall be returned to the filer or the filer shall be otherwise notified.

(7) Filings not received during regular business hours on a regular business day shall be deemed received on the next regular business day.

G. In computing periods of time, the last day shall be counted and the first day shall not be counted. Saturdays, Sundays and holidays shall be counted. If the last day of a time period falls on a day which is not a regular business day, the time period shall be extended to the close of business on the next regular business day.

H. Every filing shall be open to public inspection during regular business hours. A copy of any filing or a designated portion thereof may be obtained by making request to the superintendent and paying the charge he shall prescribe.

I. Any filing may be withdrawn at any time prior to the time it becomes effective. In the interest of efficiency, filers should notify the superintendent of withdrawals at the earliest possible date.

[7-1-97; 13.8.2.8 NMAC - Rn, 13 NMAC 8.2.8, 1-15-02; A, 3-1-06]

13.8.2.9 AMENDING FILINGS: [~~Any pending filing may be amended, provided that the Superintendent may condition acceptance of the amendment on the filer's agreement to extend the time in which the Superintendent may approve or disapprove the filing, and to waive the effect of the applicable "deemer" provision during the period of such extension.~~] Any pending filing may be amended, provided that the entire filing, including the amendment, shall be deemed made as of the date the amendment was filed, unless waived by the superintendent.

[7-1-97; 13.8.2.9 NMAC - Rn, 13 NMAC 8.2.9, 1-15-02; A, 3-1-06]

13.8.2.10 ADDITIONAL INFORMATION: The superintendent may require additional information in accordance with this section.

A. The superintendent shall notify a filer of any additional supporting data, clarification or other information he deems necessary to adequately review the filing. Alternatively or additionally, the superintendent may schedule and hold an informal public hearing for the same purpose.

B. Where additional information is sought pursuant to this section, the filing shall be deemed made [~~and the waiting period to commence~~] as of the date all requested information is provided, unless waived by the superintendent.

[7-1-97; 13.8.2.10 NMAC - Rn, 13 NMAC 8.2.10, 1-15-02; A, 3-1-06]

13.8.2.11 NOTIFICATION: The superintendent shall notify by mail or electronic media the filer and each other party of his approval or disapproval of each filing. Where a filing is disapproved, the superintendent shall state the reasons for disapproval.

[7-1-97; 13.8.2.11 NMAC - Rn, 13 NMAC 8.2.11, 1-15-02; A, 3-1-06]

13.8.2.14 COMPANY FILINGS:

A. Any insurer may make rates and rate filings on its own behalf in accordance with this section and other applicable portions of this rule.

B. Any insurer may file at any time any rate or supplementary rate information applicable to any line or part of a line of property and casualty insurance business for which the insurer is certificated.

C. Every company filing shall be accompanied by the exhibits required under13.8.2.17 NMAC [~~, except as provided in 13.8.2.26 NMAC~~].

D. Every company filing, except filings pursuant to 13.8.2.16 NMAC [~~and 13.8.2.26 NMAC~~], shall comply with 13.8.2.18 NMAC.

E. The review period for a company filing begins when the filing is received by the superintendent, unless delayed for amendment or lack of sufficient information pursuant to Chapter 59A, Article 17 NMSA 1978 and [~~this rule~~] 13.8.2 NMAC.

F. Except as provided in 13.8.2.25 NMAC, company filings based on a rate service organization advisory pure premium filing may not be used until either the superintendent has notified the rate service organization that the advisory filing is acceptable or the statutory review period has expired with no action, whichever is sooner.

[7-1-97; 13.8.2.14 NMAC - Rn & A, 13 NMAC 8.2.14, 1-15-02; A, 3-1-06]

13.8.2.17 REQUIRED EXHIBITS: [~~Rate filings shall include the following exhibits for each line of business, showing by individual insurer for the three most recently completed consecutive calendar or calendar accident years:~~

~~**A.** actual direct written premiums;~~

~~**B.** actual direct earned premiums;~~

~~**C.** actual direct paid losses;~~

~~**D.** The change in direct loss reserves during the year, including:~~

~~**(1)** reported reserves, based on actual reserves; and~~

~~**(2)** incurred but not reported reserves, based on separate calculations or equivalent to the change in reported reserves;~~

~~**E.** incurred losses, derived from the foregoing;~~

~~**F.** underlying data used to calculate any loss development factors and trend factors included in the filing, including but not limited to a description of the basis for and methods used to establish such factors;~~

~~G. actual expenses for each of the following categories:~~

~~(1) commissions;~~

~~(2) other acquisition expenses;~~

~~(3) general expenses; and~~

~~(4) taxes, licenses and fees;~~

~~H. investment income from each of the following sources, including method of calculation, allocated to the specific line of business:~~

~~(1) unearned premium reserves;~~

~~(2) loss reserves, including but not limited to IBNR;~~

~~(3) loss adjustment expense reserves;~~

~~(4) any contingency reserves; and~~

~~(5) surplus held in conjunction with the line of business.~~

~~I. average credit or debit written in conjunction with any schedule rating plan or similar plan.~~]

A. Rate filings shall include the following exhibits for each line of business, showing by individual insurer for the three most recently-completed consecutive calendar or calendar-accident years:

(1) actual direct written premiums;

(2) actual direct earned premiums;

(3) actual direct paid losses;

(4) the change in direct loss reserves during the year, including:

(a) reported reserves, based on actual reserves; and

(b) incurred but not reported reserves, based on separate calculations or equivalent to the change in reported reserves;

(5) incurred losses, derived from the foregoing;

(6) underlying data used to calculate any loss development factors and trend factors included in the filing, including but not limited to a description of the basis for and methods used to establish such factors;

(7) actual expenses for each of the following categories:

(a) commissions;

(b) other acquisition expenses;

(c) general expenses; and

(d) taxes, licenses and fees;

(8) investment income from each of the following sources, including method of calculation, allocated to the specific line of business:

(a) unearned premium reserves;

(b) loss reserves, including but not limited to IBNR;

(c) loss adjustment expense reserves;

(d) any contingency reserves; and

(e) surplus held in conjunction with the line of business; and

(9) average credit or debit written in conjunction with any schedule rating plan or similar plan.

B. If not shown in the transmittal documents, the filing shall contain an exhibit which displays the maximum percentage of rate increase that any policyholder may experience as a result of the filing.

[7-1-97; 13.8.2.17 NMAC - Rn, 13 NMAC 8.2.17, 1-15-02; A, 3-1-06]

13.8.2.18 RATEMAKING REQUIREMENTS: Rate filings are subject to the following ratemaking requirements, in addition to all other requirements prescribed by law.

A. Rate filings may be based on any reasonable base period of at least [~~two~~] three recent consecutive calendar, calendar-accident or policy years, or any combination of these, developed and trended as appropriate, unless the Superintendent finds such base to be inadequate or unreliable, in which case he shall specify the base to be used.

B. Expense data shall be derived from insurers' actual New Mexico expenses where available by line. Expenses and expense trending shall reflect actual expenses adjusted for anticipated increases or decreases on a company-by-company or other basis which accurately reflects differences in insurers' modes of operation and expense levels.

C. Rate filings shall reflect investment income allocated to the line or part of a line of New Mexico business. Investment income shall track each insurer's overall investment rate of return, including but not limited to realized capital gains. Investment income shall include income from each and every source specified in Subsection H of 13.8.2.17 NMAC.

D. Premiums, investment income, loss experience, actual expenses and all other applicable rate factors shall be adjusted to the level anticipated during the period to which the rates will apply.

[7-1-97; 13.8.2.18 NMAC - Rn, 13 NMAC 8.2.18, 1-15-02; A, 3-1-06]

13.8.2.20 RATE SERVICE ORGANIZATION ADVISORY FILINGS:

A. Any licensed rate service organization may make advisory filings within the scope of its license as provided in [~~this part and other applicable portions of this rule~~] 13.8.2 NMAC.

B. Advisory filings shall be made for informational purposes, and such uses as permitted in [~~this part~~] 13.8.2 NMAC. Advisory rate filings are limited to pure premium rates, supplementary rate information and supporting data, including loss experience, developed and trended as appropriate. Advisory rate filings shall not contain data on premiums, investment income, expenses, profit factor, dividend allowance permissible loss ratio or other factors or supporting data which could be used to develop a full rate, other than loss experience.

C. The superintendent shall review all advisory filings. The superintendent shall determine if the filing is made by a properly licensed rate service organization within the scope of its license, and if the scope of such filing is limited in accordance with [~~this rule~~] 13.8.2 NMAC, and if not, shall reject the filing. The superintendent shall also consider the rate standards contained in Section 59A-17-6 NMSA 1978 in determining whether advisory filings are acceptable.

D. An insurer may seek the superintendent's permission to base its own independent filing, or portions thereof, on information, data, statistics or pure premium rates contained in an advisory filing upon making a showing satisfactory to the superintendent that:

(1) the insurer lacks credible loss data of its own on which to base rates;

(2) the insurer's use of a uniform system of statistics, classifications, rating schedules, rating rules, underwriting rules or other similar information makes use of such supplementary rate information from an advisory filing both necessary and appropriate; provided, that [~~this subparagraph~~] Paragraph (2) of Subsection D of 13.8.2.20 NMAC applies only to statistical supplementary rate information, and does not apply to nor permit adoption of any rate, rate manual, minimum premium or policy fee; and

(3) with regard to Paragraph (1) of Subsection D of 13.8.2.20 NMAC, that such use of the advisory filing or portions thereof is appropriate because the loss experience contained in the advisory filing reasonably and accurately applies to the insurer, and will not result in rates which are excessive, inadequate or unfairly discriminatory.

[7-1-97; 13.8.2.20 NMAC - Rn, 13 NMAC 8.2.20, 1-15-02; A, 3-1-06]

13.8.2.21 ASSIGNED RISK POOL FILINGS: [~~This part applies to assigned risk plans and other residual market plans.~~]

A. For purposes of rate filings, assigned risk plans and similar residual market plans applicable to risks not insurable through the voluntary market shall be considered and treated as if the plan were a single insurer.

B. Rates for assigned risk plans and other residual market plans may be based on:

(1) the plan's own premiums, investment income, loss and expense data, and other statutory factors;

(2) premiums, investment income, loss and expense data, and other statutory factors for all New Mexico risks in the line of business as a whole; provided, that if this option is used, a reasonable, actuarially-justified surcharge may be provided to reflect any demonstrated difference between projected loss and expense experience for the plan and for the line of business as a whole. Such surcharge shall be justified on the basis of comparative loss and expense experience for at least two recent consecutive years; or

(3) any other reasonable method meeting statutory standards and approved by the superintendent.

[7-1-97; 13.8.2.21 NMAC - Rn, 13 NMAC 8.2.21, 1-15-02; A, 3-1-06]

13.8.2.22 RATES FOR GOVERNMENTAL ENTITIES: Rate filings need not be followed in connection with policies bid or to be issued to state or local governmental entities in New Mexico; provided, that no rate to any such governmental entity shall exceed the filed rate or rates which would be applicable to the entity but for the provisions of [~~this rule~~] 13.8.2 NMAC. [~~This rule~~] 13.8.2 NMAC does not authorize bidding or issuance to governmental entities of lines or types of insurance for which an insurer has not otherwise filed and obtained approval of a rate, nor does it relieve any insurer of any duty to comply with the Insurance Code or laws related to bidding, sale or issuance of insurance to governmental entities.

[7-1-97; 13.8.2.22 NMAC - Rn, 13 NMAC 8.2.22, 1-15-02; A, 3-1-06]

~~[13.8.2.25 PROPERTY AND CASUALTY FILING SUMMARY:~~]

[~~13.8.2.26~~]13.8.2.25 LIMITED EXEMPTION FROM PRIOR APPROVAL:

~~[A. Insurance rate filings shall be exempt from the requirements of 13.8.2.17 NMAC and 13.8.2.18 if:~~

~~(1) the rate filing is for commercial insurance where the insured is a business, government entity, or non-profit organization;~~

~~(2) the rate filing is for a commercial line of business, except for the following:~~

~~(a) workers compensation;~~

~~(b) medical professional liability; or~~

~~(c) ski basin liability;~~

~~(3) the rate filing does not result in a renewal rate change greater than 25% for any policyholder with current premiums less than $10,000; and~~

~~(4) the rate filing is not:~~

~~(a) a policy form filing; or~~

~~(b) a rate service organization filing or assigned risk filing.~~

~~B. Filings made pursuant to paragraph A of section 26 of 13.18.2 NMAC shall:~~

~~(1) include:~~

~~(a) a brief explanatory memorandum;~~

~~(b) a copy of the rates; and~~

~~(c) the filing summary required by section 25 of 13.8.2 NMAC;~~

~~(2) be subject to all other requirements of this rule; and~~

~~(3) be subject to the requirements of NMSA 1978, Section 59A-17-6.~~

~~C. The superintendent may at any time request an insurer to file the exhibits required by section 17 of 13.8.2 NMAC.~~

~~D. If a rate filing made pursuant to paragraph A of section 26 of 13.18.2 NMAC is based on a rate service organization filing, the rate service organization filing shall have been preauthorized for use in New Mexico.~~]

A. A commercial insurance filing shall become effective and may be used upon filing and shall be exempt from the requirement that the filing shall be made at least sixty days (or 90 days for workers compensation insurance) before its proposed effective date and from the prior approval requirements of Sections 59A-17-9 and -10 NMSA 1978 if the filing is not:

(1) for workers compensation insurance, with the exception of a company filing that does not deviate from an approved workers compensation rate service organization advisory filing;

(2) for professional liability insurance;

(3) for credit-related insurance, including but not limited to mortgage guaranty insurance, credit property insurance, collateral protection insurance, or guaranteed asset protection insurance;

(4) an assigned risk filing;

(5) for title insurance;

(6) for farm owner's insurance; or

(7) for ranch owner's insurance.

B. Filings that qualify for the limited exemption provided by Subsection A of 13.8.2.25 NMAC shall be subject to all other requirements of 13.8.2 NMAC and Chapter 59A, Article 17 NMSA 1978.

C. The filing and use of rates or rate-related rules that do not comply with or that violate provisions of the Insurance Code or administrative rules shall be subject to the administrative penalties stated in the Insurance Code, including Section 59A-1-18 NMSA 1978.

[7-1-97; 13.8.2.25 NMAC, Rn, 13 NMAC 8.2.25, 1-15-02; Repealed, 3-1-06 - Rn, 13.8.2.26 NMAC & A, 3-1-06]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

This is an amendment to 13 NMAC 8.3, Sections 1, 2, 3, 5, 6, 7, 9 and 10. This action also renumbers and reformats 13 NMAC 8.3 to 13.8.3 NMAC in accordance with the current New Mexico Administrative Code (NMAC) requirements, effective March 1, 2006.

13.8.3.1 ISSUING AGENCY: New Mexico [~~State Corporation Commission Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269~~] Public Regulation Commission Insurance Division.

[7-1-97; 13.8.3.1 NMAC - Rn & A, 13 NMAC 8.3.1, 3-1-06]

13.8.3.2 SCOPE:

[~~A. This rule applies to:~~

~~(1) casualty insurance forms;~~

~~(2) property insurance forms for risks or property located in New Mexico, including fire insurance;~~

~~(3) marine and transportation insurance forms;~~

~~(4) vehicle insurance forms on risks or operations in New Mexico including:~~

~~(a) physical damage;~~

~~(b) public liability and property damage;~~

~~(c) cargo;~~

~~(d) medical payments.~~

~~B. This rule does not apply to:~~

~~(1) fidelity, surety and guaranty bonds on casualty risks or operations in New Mexico;~~

~~(2) accident and health insurance forms;~~

~~(3) marine and transportation forms which by general custom of the business are not written according to manual rates or rating plans;~~

~~(4) wet marine insurance forms; or~~

~~(5) reinsurance forms other than joint reinsurance forms~~.]

This rule applies to policies of all property, casualty, vehicle, marine and transportation, surety and title insurance coverages that are within the scope of Chapter 59A, Article 18 NMSA 1978.

[6-3-70; 13.8.3.2 NMAC - Rn & A, 13 NMAC 8.3.2, 3-1-06]

[See Section 59A-18-2 NMSA 1978 for the definition of policy and Chapter 59A, Article 7 NMSA 1978 for definitions of

kinds of insurance.]

13.8.3.3 STATUTORY AUTHORITY: Sections 59A-2-9, 59A-18-12 [~~,59A-18-13~~] and 59A-18-14 NMSA 1978.
[7-1-97; 13.8.3.3 NMAC - Rn & A, 13 NMAC 8.3.3, 3-1-06]

13.8.3.5 EFFECTIVE DATE: June 3, 1970, unless a later date is cited at the end of a section [~~or paragraph~~]. [~~Repromulgated in NMAC format effective July 1, 1997~~].
[7-1-97; 13.8.3.5 NMAC - Rn & A, 13 NMAC 8.3.5, 3-1-06]
[~~Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.~~]

13.8.3.6 OBJECTIVE: The purpose of this rule is to implement Sections 59A-18-12 [~~,59A-18-13~~] and 59A-18-14 NMSA 1978 by specifying the requirements for [~~casualty, property, title and vehicle~~] property, casualty, vehicle, marine and transportation, surety and title insurance policy forms.
[7-1-97; 13.8.3.6 NMAC - Rn & A, 13 NMAC 8.3.6, 3-1-06]

13.8.3.7 DEFINITIONS: [~~RESERVED~~] **"Commercial insurance"** means property or casualty insurance that is within the scope of Chapter 59A, Article 17 NMSA 1978 where the insured is a business, government entity or non-profit organization.
[7-1-97; 13.8.3.7 NMAC - Rn & A, 13 NMAC 8.3.7, 3-1-06]

13.8.3.9 [~~PRIOR APPROVAL REQUIRED:~~ ~~No policy form may be issued for use in New Mexico until it has been approved by the superintendent of insurance.~~] **LIMITED EXEMPTION FROM PRIOR APPROVAL:**

A. A commercial insurance filing shall become effective and may be used upon filing and shall be exempt from the requirement that the filing shall be made at least sixty days before its proposed effective date and from the prior approval requirements of Section 59A-18-12 NMSA 1978 if the filing is not:

(1) for workers compensation insurance, with the exception of a company filing that does not deviate from an approved workers compensation rate service organization advisory filing;

(2) for professional liability insurance;

(3) for credit-related insurance, including but not limited to mortgage guaranty insurance, credit property insurance, collateral protection insurance, or guaranteed asset protection insurance;

(4) an assigned risk filing;

(5) for title insurance;

(6) for farm owner's insurance; or

(7) for ranch owner's insurance.

B. Filings that qualify for the limited exemption provided by Subsection A of 13.8.3.9 NMAC shall be subject to all other requirements of 13.8.3 NMAC and Chapter 59A, Article 18 NMSA 1978.

C. The filing and use of forms that do not comply with or that violate provisions of the Insurance Code or administrative rules shall be subject to the administrative penalties stated in the Insurance Code, including Section 59A-1-18 NMSA 1978.
[7-1-97; 13.8.3.9 NMAC - Rn & A, 13 NMAC 8.3.9, 3-1-06]

13.8.3.10 FILING REQUIREMENTS:

[~~**A. Number of copies:** The filer shall prepare the letter for transmission in duplicate. A stamped, self-addressed envelope must be included. The department of insurance shall retain one copy and return the other to the filer with indication of the action taken by the department.~~

~~**B. Name and address:** The name and address of the insurer making the filing shall be clearly indicated. If group insurer stationery is used, the filer must identify the insurer or insurers for whom the filing is intended to be made.~~

~~**C. Description:** The filer shall give a description of the policy forms, endorsements, riders or applications being filed, identifying specifically the policy form affected and indicating whether it is a new policy form or supersedes current policy form filings, describing the changes specifically. This description may be given generally by reference to the title of the policy form, if any, enclosed with the filing.~~

~~**D. Effective date:** The filer shall state in the letter the date that the insurer proposes the form to become effective, but no earlier than the mandatory 60-day waiting period.~~]

A. Separate filing: Form filings shall be made separately from rate or rate-related rule filings. Filings may be made by mail, courier, the national association of insurance commissioner's system for electronic rate and forms filing (SERFF) or in person and shall be addressed to the superintendent.

B. Transmittal documents: All form filings shall be submitted with completed transmittal documents in substantially the format of the appropriate current national association of insurance commissioners' uniform transmittal documents which are available online at www.naic.org.

(1) The *property and casualty transmittal* document shall include:

(a) group name and "NAIC" number;

(b) company name, domicile, "NAIC" number and "FEIN" number;

(c) company tracking number;

(d) contact information of filer or corporate officer, including: name and address; title; telephone numbers; fax numbers and e-mail address;

(e) signature and printed name of authorized filer;

(f) type and sub-type of insurance;

(g) state specific product code, if applicable;

(h) company program title;

(i) filing type;

(j) effective date requested, including: new or renewal;

(k) a statement indicating whether the filing is a reference filing, including the reference organization name and reference organization number and title, if applicable;

(l) company's date of filing;

(m) status of filing in domicile;

(n) company tracking number;

(o) filing description; and

(p) the appropriate filing fees, including check number and fee amount, if applicable.

(2) The *form filing schedule* document shall include:

(a) company tracking number;

(b) corresponding company tracking number of rate or rule filing, if applicable; and

(c) a description of the filing, including:

(i) form name, description and synopsis;

(ii) form number, including edition date;

(iii) a statement whether the filing is new, a replacement or a withdrawal;

(iv) if the filing is a replacement, the form number it replaces; and

(v) the previous state filing number.

C. Number of copies: The filer shall prepare the letter for transmission in duplicate. A stamped, self-addressed envelope must be included. The insurance division shall retain one copy and return the other to the filer with indication of the action taken by the division.

D. Name and address: The name and address of the insurer making the filing shall be clearly indicated. If group

insurer stationery is used, the filer must identify the insurer or insurers for whom the filing is intended to be made.

E. Description: The filer shall give a description of the policy forms, endorsements, riders or applications being filed, identifying specifically the policy form affected and indicating whether it is a new policy form or supersedes current policy form filings, specifically describing the changes, including whether any of the changes include limitations, reductions or restrictions in coverages. This description may be given generally by reference to the title of the policy form, if any, enclosed with the filing.

F. Effective date: The filer shall state in the letter the date that the insurer proposes the form to become effective.

[6-3-70; 7-1-97; 13.8.3.10 NMAC - Rn & A, 13 NMAC 8.3.10, 3-1-06]

End of Adopted Rules Section

SUBMITTAL DEADLINES AND PUBLICATION DATES

2006

Volume XVII	Submittal Deadline	Publication Date
Issue Number 1	January 3	January 17
Issue Number 2	January 18	January 31
Issue Number 3	February 1	February 14
Issue Number 4	February 15	February 28
Issue Number 5	March 1	March 15
Issue Number 6	March 16	March 31
Issue Number 7	April 3	April 14
Issue Number 8	April 17	April 28
Issue Number 9	May 1	May 15
Issue Number 10	May 16	May 31
Issue Number 11	June 1	June 15
Issue Number 12	June 16	June 30
Issue Number 13	July 3	July 17
Issue Number 14	July 18	July 31
Issue Number 15	August 1	August 15
Issue Number 16	August 16	August 31
Issue Number 17	September 1	September 15
Issue Number 18	September 18	September 29
Issue Number 19	October 2	October 16
Issue Number 20	October 17	October 31
Issue Number 21	November 1	November 15
Issue Number 22	November 16	November 30
Issue Number 23	December 1	December 14
Issue Number 24	December 15	December 29

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