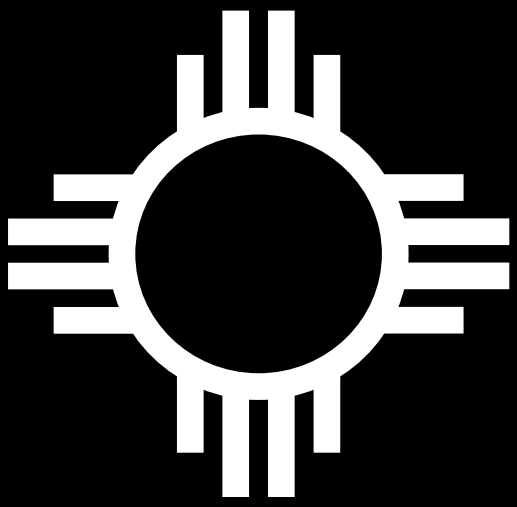
NEW MEXICO REGISTER



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October 15, 2014

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
2014

New Mexico Register

Volume XXV, Number 19
October 15, 2014

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A=***Amended***, E=***Emergency***, N=***New***, R=***Repealed***, Rn=***Renumbered***

Other Material Related to Administrative Law

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Notices of Rulemaking and Proposed Rules

NEW MEXICO DEPARTMENT OF HEALTH

NOTICE OF PUBLIC HEARING

The New Mexico Department of Health will hold a public hearing on the proposed addition of 7.27.2.16 NMAC ("Criminal History Screening"). The hearing will be held on Thursday, November 20, 2014 at 9:30 a.m. in the Harold Runnels Building auditorium, located at 1190 St. Francis Drive in Santa Fe, New Mexico.

The public hearing will be conducted to receive public comment regarding the proposed addition of 7.27.2.16 NMAC. The proposed section would include standards for criminal history screening of emergency medical services (EMS) applicants and licensees within the EMS licensing rule.

A copy of the proposed rule section may be obtained from, and written comments may be submitted to:

Charles Schroeder, EMS Program Manager
EMS Bureau
New Mexico Department of Health
1301 Siler Rd., Bldg. F
Santa Fe, NM 87507
(505) 476-8246

If you are an individual with a disability who is in need of special assistance or accommodations to attend or participate in the hearing, please contact Charles Schroeder at the above address or telephone number. The Department requests at least ten (10) days' advance notice for special accommodations requests.

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

ATHLETIC COMMISSION

REGULAR MEETING/RULE HEARING NOTICE

Notice is hereby given that the New Mexico Athletic Commission (hereafter, "Commission") will convene a Rule Hearing at 4:00 p.m. on Tuesday, November 18, 2014, at the Regulation and Licensing Department, located at 5200 Oakland Avenue NE, Albuquerque, New Mexico 87122.

The purpose of the Rule Hearing is to consider adoption of proposed amendments and additions to the following Board Rules and Regulations in 15.6.1.21 Change of decision, 15.6.12.31 Reserved change of decision, 15.6.15.2 Scope.

Persons desiring to present their views on the proposed rules may obtain a copy from the Board's website at www.rld.state.nm.us, write to request draft copies from the Board office at the Toney Anaya Building located at 2550 Cerrillos Road in Santa Fe, New Mexico, 87505, or call (505) 476-4622 after October 15, 2014. In order for the Board members to review the comments in their meeting packets prior to the meeting, persons wishing to make comments regarding the proposed rules must present them to the Board Office in writing by close of business day on November 8, 2014. Persons wishing to present their comments at the Rule Hearing will need (7) copies of any comments or proposed changes for distribution to the Board and staff.

A copy of the agenda will be available at least 72 hours prior to the meeting and may be obtained at the Board office located on the 2nd Floor of the Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, NM, or by calling the Board office at (505) 476-4622 and will also be posted on our website at www.rld.state.nm.us, New Mexico Athletic Commission, under Members and Meetings.

If you have questions, or if you are an individual with a disability who wishes to attend the hearing or meeting, but you need a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to participate, please call the Board office at (505) 476-4622 at least two weeks prior to the meeting or as soon as possible.

Please send your invoice with proof of publication to the Board Office at the above address.

Thank You,
Richard Espinoza
Executive Director

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

CONSTRUCTION INDUSTRIES DIVISION

STATE OF NEW MEXICO
CONSTRUCTION INDUSTRIES COMMISSION
NOTICE OF PUBLIC HEARING

The Construction Industries Commission will convene a public hearing on proposed changes to 14.8.2 NMAC - New Mexico Plumbing Code, 14.8.3 NMAC - New Mexico Swimming Pool, Spa and Hot Tub Code, 14.9.2 NMAC - New Mexico Mechanical Code, and 14.9.6 NMAC - New Mexico Solar Energy Code before its designated hearing officer, at which any interested person is invited submit data, views or arguments on the proposed changes, either orally or in writing, and to examine witnesses testifying at the hearing. The public hearing is scheduled as follows:

9:00 a.m., November 3rd, 2014 at the NM Regulation and Licensing Department (Main Conference Room), located at 5200 Oakland Avenue NE, in Albuquerque, NM.

Please Note: All persons wishing to participate in the public hearing remotely may do so telephonically dialing into:

Dial-in Number: (712) 432-1212

Meeting ID: 788-223-117

Interested persons may secure copies of the proposed changes by accessing the CID website (www.rld.state.nm.us/construction) or by request from the Santa Fe CID Office - Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, NM 87505. If you cannot attend the hearing, you may send your written comments to: Construction Industries Division, 2550 Cerrillos Road, Santa Fe, New Mexico 87505, Attention: Public Comments. Written comments may also be faxed to (505) 476-4702. All comments must be received no later than 5:00 p.m., on November 2nd, 2014. If you require special accommodations to attend the hearing, please notify CID by phone, email, or fax, of such needs no later than October 31st, 2014. Telephone: 505-476-4700 (option "0"). Email: jerome.baca@state.nm.us; Fax No. (505) 476-4702.

End of Notices and Proposed Rules Section

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Adopted Rules

NEW MEXICO DEPARTMENT OF GAME AND FISH

This is an amendment to 19.31.3 NMAC, Section 8, effective 4/01/2015.

19.31.3.8 PUBLIC LICENSES AND PERMITS - APPLICATION FOR:

A. Application form: Application for all public licenses and permits shall be made on the standard application form provided by the department of game and fish.

B. Application deadline(s): Applications for all population management hunts, turkey, pronghorn antelope, elk, bighorn sheep, bear, deer, oryx, javelina, and ibex hunts must be received, in the Santa Fe office only, by 5:00 p.m. on dates set by the state game commission.

C. Mailed application deadline: Mailed applications postmarked, but not delivered by the deadline date, will be accepted by the Santa Fe office up to five working days after that deadline.

D. One applicant per application: No more than one person may apply under each application number for bighorn sheep, bear,[~~ibex,~~] and GMU 5A private land deer.

E. Two applicants per application: No more than two persons may apply under the same application number for turkey, ibex and oryx.

F. Four applicants per application: No more than four persons may apply under the same application number for deer, elk, pronghorn antelope, Barbary sheep and javelina.

G. Resident and non-resident application combination: Any mixture or combination of residents and non-residents may make application for special drawing providing the number of applicants does not exceed the restriction of this section (subsection D, E or F).

H. Applications rejected: Applications for licenses may be rejected by the department if an applicant did not:

(1) apply on the proper form as designated by the director;

(2) submit the correct or required information;

(3) submit the correct license or application fee, and any other required fee;

(4) meet the deadline date;

(5) comply with a current statute or rule, or did not submit valid written landowner permission when specified by rule.

I. More applications than permits: If more applications for public licenses or permits are received than there are licenses or permits available, the available licenses or permits shall be allotted by means of a public drawing.

J. Increase in licenses or permits: The number of licenses or permits available may be increased to accommodate corrections or errors by the department which results in the addition of names to the successful list.

K. Additional choices: Applicants for public licenses may designate additional choices for hunt periods.

L. Application categories: Applications for special drawing hunts will be placed into the appropriate categories, as specified in 17-3-16 NMSA 1978 by department personnel or their designee. Special drawings shall continue to draw applicants from the appropriate drawing pool progressively for each respective hunt code, starting with first choice applicants, then proceeding to second and subsequent choice applicants until the quota has been met or the pool of applicants has been exhausted.

M. Resident and non-resident applications:

(1) To be placed in the separate pool designated for guided hunts, an applicant must have a valid registration number issued to a New Mexico outfitter as prescribed in Paragraph H of Section 17-3-6 NMSA 1978, on their application.

(2) For an application to be successfully drawn, there must be a sufficient number of licenses or permits available for that hunt code to accommodate all applicants from their respective drawing pools.

(3) Any licenses left over from the appropriate drawing pool will be allocated as prescribed in Paragraph C of Section 17-3-16 NMSA 1978 Compilation.

N. New Mexico department game and fish customer identification number: All persons making application to the department for hunt drawings for public licenses and permits and private landowner authorizations shall submit on the application a "New Mexico department of game and fish (NMDGF) customer identification number".

(1) **"**NMDGF customer identification number" shall be obtained only from the department and must be obtained prior to the submission of any application or private landowner authorization.

(2) Each person making application for public drawing license, permit or private landowner authorization must use their own valid NMDGF customer identification number on his or her application.

(3) Any application received without a valid NMDGF customer identification number or false NMDGF customer number will be rejected.

O. Trapper license restriction: The number of trapper licenses shall be unlimited and available only through department offices or the department's web site.

P. Director's Authority to Adjust Licenses and Permits: The director may adjust licenses or permit numbers for special drawings, by no more than one (1) per hunt code, to comply with Chapter 17 NMSA 1978 and its corresponding rules.

[19.31.3.8 NMAC - Rp, 19.31.3.8 NMAC, 12-30-04; A, 4-1-07; A, 3-16-09; A, 3-31-10; A, 3-15-11; A, 9-30-11; A, 04-01-2015]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.200.430 NMAC, Sections 9 - 20, effective October 15, 2014.

8.200.430.9 RECIPIENT RIGHTS AND RESPONSIBILITIES:

A. An individual has the right to apply for medicaid and other health care programs HSD administers regardless of whether it appears he or she may be eligible.

(1) Income support division (ISD) determines eligibility for [~~medicaid health care programs~~] the medical assistance division's medical assistance programs (MAP), unless otherwise determined by another entity as stated in 8.200.400 NMAC. A decision shall be made promptly on applications in accordance with the timeliness standards set forth in [~~8.100.130.11~~] 8.100.130 NMAC.

(2) Individuals who might be eligible for supplemental security income (SSI) are referred to the social security administration (SSA) office to apply.

B. Application: A paper or electronic application is required from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant may

complete a joint [~~medicaid~~] MAP, cash assistance, supplemental nutrition assistance program (SNAP) and low income home energy assistance (LIHEAP) application or a [~~medicaid-only~~] MAP-only application.

(1) The following do not require an application unless a re-determination is due in that month or the following month, as applicable:

(a) switching from one of the medical assistance for women, children (MAWC) and families [~~medical assistance division (MAD)~~] MAP categories to another;

(b) switching between medicaid and refugee medical assistance; and

(c) switching to or from one of the long term care [~~medicaid~~] MAP categories.

(2) Medicare savings programs (MSP):

(a) A [~~medicaid~~] MAP eligible recipient receiving full benefits is automatically deemed eligible for MSP when she or he receives free medicare Part-A hospital insurance; the eligible recipient does not have to apply for medicare MSP;

(b) When an individual is not eligible for free medicare Part A hospital insurance, a separate application for the MAP qualified medicare beneficiary (QMB) eligibility category 040 is required. Individuals must apply for medicare Part A with the SSA. This is called, "conditional Part A" because they will receive medicare Part A on the condition that the MAP QMB category of eligibility is approved. When QMB is approved, the cost of the premium for Part A will be covered by [~~medicaid~~] MAD.

C. Responsibility in the application or recertification process: The applicant or the re-determining eligible recipient is responsible for providing verification of eligibility. Refer to 8.100.130 NMAC.

(1) An applicant or an eligible recipient's failure to provide necessary verification results in [~~medicaid~~] MAP ineligibility.

(2) An applicant or a re-determining eligible recipient must give HSD permission to contact other individuals, agencies, or sources of information which are necessary to establish eligibility.

[8.200.430.9 NMAC - Rp, 8.200.430.9 NMAC, 1-1-14; A, 10-15-14]

8.200.430.10 FREEDOM OF CHOICE: Except when specifically waived from MAD, an eligible recipient has the freedom to obtain [~~medical~~] physical and behavioral health services from a MAD provider of his or her choice.

[8.200.430.10 NMAC - Rp, 8.200.430.10 NMAC, 1-1-14; A, 10-15-14]

8.200.430.11 RELEASE OF INFORMATION: By signing the [~~medicaid~~] MAP application, an applicant or a re-determining eligible recipient gives HSD explicit consent to release information to applicable state or federal agencies, [~~medical~~] physical or behavioral health providers, or an HSD designee when the information is needed to provide, monitor, or approve [~~medicaid~~] MAD services. [~~Medical~~] Physical and behavioral health information is confidential and is subject to the standards for confidentiality per 8.300.11 NMAC.

[8.200.430.11 NMAC - Rp, 8.200.430.11 NMAC, 1-1-14; A, 10-15-14]

8.200.430.12 RIGHT TO HEARING: [~~An applicant or an eligible recipient is entitled to adequate notice of state agency actions and for an opportunity to have an impartial review of those decisions at an administrative hearing. This includes any action to deny or terminate medicaid or another health care program's eligibility or deny, terminate, suspend or reduce a medicaid covered service [42 CFR Section 431.220(a)(1)(2)].~~

~~A. Adequate notice rules regarding medicaid eligibility are detailed at 8.100.180 NMAC. Fair hearing rules regarding medicaid eligibility are detailed at 8.100.970 NMAC.~~

~~B. Adequate notice and recipient hearing rules regarding MAD covered services are detailed in 8.352.2 NMAC.~~] An applicant or an eligible recipient is entitled to adequate notice of a HSD adverse action regarding his or her termination or re-categorization of his or her MAP category of eligibility. The applicant or re-determining eligible recipient has specific rights and responsibilities when requesting a HSD administrative hearing. A HSD administrative hearing affords the applicant or re-determining eligible recipient the opportunity to have an impartial review of these decisions. See 8.352.2, 8.100.180 and 8.100.970 NMAC for a detailed description of these rights, responsibilities and the HSD administrative hearing process. 8.352.2 NMAC further details the rights, responsibilities and the HSD administrative hearing process for other adverse actions MAD, its utilization review contractor or a HSD contracted managed care organization (MCO) may initiate (42 CFR Section 431.220(a)(1)(2)).

[8.200.430.12 NMAC - Rp, 8.200.430.12 NMAC, 1-1-14; A, 10-15-14]

8.200.430.13 ASSIGNMENT OF SUPPORT: As a condition of [~~MAD~~] MAP eligibility, HSD requires an applicant or a re-determining eligible recipient to assign his or her medical care support rights to HSD for medical support and any third party payments. The assignment authorizes HSD to pursue and make recoveries from liable third parties (42 CFR 433.146; NMSA 1978 27-2-28 (G)).

A. **Assigning medical support rights**: The assignment to HSD of an eligible recipient's rights to medical support and payments occurs automatically under New Mexico law when the applicant or the re-determining eligible recipient signs the application.

B. **Third party liability (TPL):** This section describes [~~HSD~~] HSD's responsibility to identify and collect from primarily responsible third parties and [~~recipient~~] the eligible recipient's responsibility to cooperate with HSD to uncover such payments. [~~Medicaid~~] MAD is the payer of last resort. If other third party resources are available, these health care resources must be used before [~~medicaid~~] MAD makes a reimbursement. As a condition of [~~medicaid~~] MAP eligibility, an applicant assigns his or her rights to [~~medical~~] physical and behavioral health support and payments to HSD and promises to cooperate in identifying, pursuing, and collecting payments from these resources. Third party resources include the gross recovery by [~~a~~] eligible recipient, including personal injury protection benefits, before any reduction in attorney's fees or costs, obtained through settlement or verdict, for personal injury negligence or intentional tort claims or actions, up to the full amount of [~~medicaid~~] MAD payments for treatment of injuries causally related to the occurrence that is the subject of the claim or action.

(1) Required TPL information: During the initial determination or [~~re-determinination~~] re-determination of eligibility for [~~medicaid services~~] MAP enrollment, ISD must obtain information about TPL from either the applicant or the re-determining eligible recipient.

(a) HSD is required to take all reasonable measures to determine the legal liability of third parties, including health insurers in paying for the [~~medical~~] physical and behavioral health services furnished to an eligible recipient (42 CFR 433.138(a)).

(b) HSD uses the information collected at the time of determination in order for [~~medicaid~~] MAD to pursue claims against third parties.

(2) Availability of health insurance: If an applicant or an eligible recipient has health insurance, the applicant or the eligible recipient shall notify ISD. ISD must collect all relevant

information, including name and address of the insurance company; individuals covered by the policy, effective dates, covered services, and appropriate policy numbers.

(a) An applicant or an eligible recipient with health insurance coverage or coverage by a health maintenance organization (HMO) or other managed care plan (plan) must be given a copy of the TPL recipient information letter.

(b) If there is an absent parent, ISD may request the absent parent's name and social security number (SSN).

(c) ISD must determine if an absent parent, relative, applicant or any member of the household is employed and has health insurance coverage.

(3) Eligible recipients with health insurance coverage: An applicant or an eligible recipient must inform [~~medicaid~~] his or her MAD providers of his or her TPL. An applicant or an eligible recipient must report changes to or terminations of insurance coverage to ISD. If an applicant or an eligible recipient has health coverage through an HMO or plan, payment from [~~medicaid~~] MAD is limited to applicable copayments required under the HMO or plan and to [~~medicaid~~] MAD covered services documented in writing as exclusions by the HMO or plan.

(a) If the HMO or plan uses a drug formulary, the medical director of the HMO or plan must sign and attach a written certification for each drug claim to document that a pharmaceutical product is not covered by the HMO or plan. The signature is a certification that the HMO or plan drug formulary does not contain a therapeutic equivalent that adequately treats the [~~medical~~] physical or behavioral health condition of the HMO or plan subscriber.

(b) [~~Medical~~] Physical and behavioral health services not included in the HMO or plan are covered by MAD only after review of the documentation and on approval by MAD.

(c) An applicant or an eligible recipient covered by an HMO or plan is responsible for payment of medical services obtained outside the HMO or plan and for medical services obtained without complying with the rules or policies of the HMO or plan.

(d) An applicant or an eligible recipient living outside an HMO or plan coverage area may request a waiver of the requirement to use HMO or plan providers and services. The applicant or the eligible recipient for whom a coverage waiver is approved by MAD may receive reimbursement for expenses which allow him or her to travel to an HMO or plan participating provider, even when the provider is not located near the applicant or the eligible recipient's residence.

(4) Potential health care resources: ISD must evaluate the presence of a TPL source if certain factors are identified during the [~~medicaid~~] MAP eligibility interview.

(a) When the age of the applicant or the eligible recipient is over 65 years old medicare must be explored. A student, especially a college student, may have health or accident insurance through his or her school.

(b) An application on behalf of deceased individual must be examined for "last illness" coverage through a life insurance policy.

(c) Certain specific income sources are indicators of possible TPL which include:

(i) railroad retirement benefits and social security retirement or disability benefits indicating eligibility for Title XVIII (medicare) benefits;

(ii) workers' compensation (WC) benefits paid to employees who suffer an injury or accident caused by conditions arising from employment; these benefits may compensate employees for [~~medical~~] physical and behavioral health expenses and lost income; payments for [~~medical~~] physical and behavioral health expenses may be made as [~~medical~~] physical and behavioral health bills are incurred or as a lump sum award;

(iii) black lung benefits payable under the coal mine workers' compensation program, administered by the federal department of labor (DOL), can produce benefits similar to railroad retirement benefits if the treatment for illness is related to the diagnosis of pneumoconiosis; beneficiaries are reimbursed only if services are rendered by specific providers, authorized by the DOL; black lung payments are made monthly and [~~medical~~] physical and behavioral health expenses are paid as they are incurred; and

(iv) Title IV-D support payments or financial support payments from an absent parent may indicate the potential for [~~medical~~] physical and behavioral health support; if a custodial party does not have health insurance that meets a minimum standard, the court in a divorce, separation or custody and support proceeding may order the parent(s) with the obligation of support to purchase insurance for the eligible recipient child (45 CFR 303.31(b)(1); NMSA 1978, Section 40-4C-4(A)(1)); insurance can be obtained through the parent's employer or union (NMSA 1978, Section 40-4C-4(A)(2)); parents may be ordered to pay all or a portion of the [~~medical~~] physical and behavioral health [~~or dental~~] expenses; for purposes of [~~medical~~] physical and behavioral health support, the minimum standards of acceptable coverage, deductibles, coinsurance, lifetime benefits, out-of-pocket expenses, co-payments, and plan requirements are the minimum standards of health insurance policies and managed care plans established for small businesses in New Mexico; see New Mexico insurance code.

(d) An applicant or an eligible recipient has earned income: Earned income may indicate [~~medical~~] physical, behavioral health and health insurance made available by an employer.

(e) Work history or military services: Work history may indicate eligibility for other cash and [~~medical~~] physical and behavioral benefits. Previous military service suggests the potential for veterans administration (VA) or department of defense (DOD) health care, including the civilian health and the medical program of the United States (CHAMPUS), for individuals who reside within a 40-mile radius of a military health care facility. An applicant or an eligible recipient who is eligible for DOD health care must obtain certification of non-availability of medical services from the base health benefits advisor in order to be eligible for CHAMPUS.

(f) An applicant or an eligible recipient's expenses show insurance premium payments: Monthly expense information may show that the applicant or the eligible recipient pays private insurance premiums or is enrolled in an HMO or plan.

(g) The applicant or the eligible recipient has a disability: Disability information contained in applications or brought up during interviews may indicate casualties or accidents involving legally responsible third parties.

(h) The applicant or the eligible recipient has a chronic disease: Individuals with chronic renal disease are probably entitled to medicare. Applications for social security disability may be indicative of medicare coverage.

(5) Communicating TPL information: Information concerning health insurance or health plans is collected and transmitted to MAD by ISD, child support enforcement division (CSED), SSA, and the children, youth and families department (CYFD).

[8.200.430.13 NMAC - Rp, 8.200.430.13

NMAC, 1-1-14; A, 10-15-14]

8.200.430.14 ELIGIBLE RECIPIENT RESPONSIBILITY TO COOPERATE WITH ASSIGNMENT OF SUPPORT RIGHTS:

A. **Cooperation:** As a condition of [~~medicaid~~] MAP eligibility, an applicant or an eligible recipient must cooperate with HSD to:

(1) obtain [~~medical~~] physical and behavioral health support and payments for his or herself and other individuals for whom he or she can legally assign rights;

(2) pursue liable third parties by identifying individuals and providing information to HSD;

(3) cooperate with CSED to establish paternity and medical support as appropriate, see 8.50.105.12 NMAC;

(4) appear at a state or local office designated by HSD to give information or evidence relevant to the case, appear as a witness at a court or other proceeding or give information or attest to lack of information, under penalty of perjury;

(5) refund HSD any money received for [~~medical~~] physical or behavioral health care that has already been paid; this includes payments received from insurance companies, personal injury settlements, and any other liable third party; and

(6) respond to the trauma inquiry letter that is mailed to an eligible recipient (42 CFR 433.138(4)); the letter asks an eligible recipient to provide more information about possible accidents, causes of accidents, and whether legal counsel has been obtained (42 CFR 433.147; 45 CFR 232.42, 232.43; NMSA 1978 27-2-28(G)(3)).

B. **Good cause waiver of cooperation:** The requirements for cooperation may be waived by HSD if it decides that the applicant or the eligible recipient has good cause for refusing to cooperate. Waivers can be obtained for cooperating with CSED. The applicant or the eligible recipient should request a good cause waiver from CSED per 8.50.105.14 NMAC.

C. **Penalties for failure to cooperate:**

(1) When the parent, the specified relative or legal guardian fails or refuses to cooperate, the parent or specified relative will not be eligible for [~~medicaid~~] MAD services. The eligible recipient child maintains [~~medicaid~~] MAP eligibility provided all other eligibility criteria are met.

(2) When the parent or the specified relative fails or refuses to refund payments received from insurance or other settlement sources, such as personal injury case awards, he or she is not eligible for [~~medicaid~~] MAD services for one year and until full restitution has been made to HSD. The eligible recipient child maintains [~~medicaid~~] MAP eligibility provided all other eligibility criteria are met.

[8.200.430.14 NMAC - Rp, 8.200.430.14 NMAC, 1-1-14; A, 10-15-14]

8.200.430.15 ELIGIBLE RECIPIENT RESPONSIBILITY TO GIVE PROVIDER PROPER IDENTIFICATION AND NOTICE OF ELIGIBILITY CHANGES:

A. An eligible recipient is responsible for presenting a current [~~medicaid~~] MAP eligibility card and evidence of any other health insurance to a [~~medicaid~~] MAD provider each time service is requested.

(1) An eligible recipient is responsible for any financial liability incurred if he or she fails to furnish current [~~medicaid~~] MAP eligibility identification before the receipt of a service and as a result the provider fails to adhere to MAD rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the eligible recipient and the provider. An individual is financially responsible for services received if he or she was not eligible for [~~medicaid~~] MAD services on the date services are furnished.

(2) When a provider bills [~~medicaid~~] MAD and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by [~~medicaid~~] MAP ineligibility or by an eligible recipient's failure to furnish [~~medicaid~~] MAP identification in a timely manner.

(3) If an eligible recipient fails to notify the provider that he or she has received services that are limited by time or amount, the eligible recipient is responsible for payment of the service prior to rendering the service if the provider made reasonable efforts to verify whether the eligible recipient has already received services.

B. Notification of providers following retroactive eligibility determinations: If an eligibility determination is made, the eligible recipient is responsible for notifying MAD providers of this eligibility determination. When an individual receives retro [~~medicaid~~] MAP eligibility, the now-eligible recipient must notify all of his or her [~~medicaid~~] MAD providers of his or her change of eligibility. If the eligible recipient fails to notify the provider and the provider can no longer file a claim for reimbursement, the eligible recipient becomes the responsible payer for those services.

C. Notification if an eligible recipient has private insurance: If an eligible recipient is covered under a private health insurance policy or health plan, he or she is required to inform his or her [~~medicaid~~] MAD providers of the private health coverage, including applicable policy numbers and special claim forms.

[8.200.430.15 NMAC - Rp, 8.200.430.15 NMAC, 1-1-14; A, 10-15-14]

8.200.430.16 ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES:

A. A [~~medicaid~~] MAD provider agrees to accept the amount paid as payment in full with the exception of co-payment amounts required in certain [~~medicaid~~] MAP eligibility categories (42 CFR 447.15). Other than the co-payments, a provider cannot bill an eligible recipient for any unpaid portion of the bill (balance billing) or for a claim that is not paid because of a provider administrative error or failure of multiple providers to communicate eligibility information. A native American eligible recipient is exempt from co-payment requirements.

(1) An eligible recipient is responsible for any financial liability incurred if he or she fails to furnish current [~~medicaid~~] MAP eligibility identification before the receipt of a [~~medicaid~~] MAP service and as a result the provider fails to adhere to [~~medicaid~~] MAD reimbursement rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the eligible recipient and the MAD provider. An individual is financially responsible for services received if he or she was not eligible for [~~medicaid~~] MAD services on the date services are furnished.

(2) When a provider bills [~~medicaid~~] MAD and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by [~~medicaid~~] MAP ineligibility or by an eligible recipient's failure to furnish [~~medicaid~~] MAP identification at the time of service.

(3) If an eligible recipient fails to notify a provider that he or she has received services that are limited by time or amount, the eligible recipient is responsible to pay for services if, before furnishing the services, the provider makes reasonable efforts to verify whether the eligible recipient has already received services.

B. Failure of an eligible recipient to follow his or her privately held health insurance carrier's requirements: An eligible recipient must be aware of the

physician, pharmacy, hospital, and other providers who participate in his or her HMO or other managed care plan. An eligible recipient is responsible for payment for services if he or she uses a provider who is not a participant in his or her plan or if he or she receives any services without complying with the rules, policies, and procedures of his or her plan.

C. Other eligible recipient payment responsibilities: If all the following conditions are met before a MAD service is furnished, the eligible recipient can be billed directly by a [~~medicaid~~] MAD provider for services and is liable for payment:

(1) the eligible recipient is advised by a provider that the particular service is not covered by [~~medicaid~~] MAD or is advised by a provider that he or she is not a [~~medicaid~~] MAD provider;

(2) the eligible recipient is informed by a provider of the necessity, options, and charges for the services and the option of going to another provider who is a [~~medicaid~~] MAD provider; and

(3) the eligible recipient agrees in writing to have the service provided with full knowledge that he or she is financially responsible for the payment.

D. Children's health insurance program (CHIP) and working disabled individuals (WDI) co-payments: It is the eligible recipient's responsibility to pay the co-payment to the [~~medicaid~~] MAD provider.

[~~(1) WDI co-payment requirements are the following:~~

~~(a) $7 per outpatient physician visit to a physician or other practitioner, dental visit, therapy session, or behavioral health service session;~~

~~(b) $20 per emergency room (ER) visit;~~

~~(c) $28 for non emergent use of the ER;~~

~~(d) $30 per inpatient hospital admission;~~

~~(e) $5 per drug item (does not apply if the $8 co-payment for a brand name drug is assessed); and~~

~~(f) $8 for a brand name drug when there is a less expensive therapeutically equivalent drug on the preferred drug list (PDL) unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.~~

~~(2) CHIP co-payment requirements are the following:~~

~~(a) $5 per outpatient physician visit to a physician or other practitioner, dental visit, therapy session, or behavioral health service session;~~

~~(b) $15 per ER visit;~~

~~(c) $50 for non emergent use of the ER;~~

~~(d) $25 per inpatient hospital admission;~~

~~(e) $2 per drug item (does not apply if the $5 co-payment for a brand name drug is assessed); and~~

~~(f) $5 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.~~

~~E. The following exemptions from co-payment responsibilities for WDI and CHIP eligible recipients apply:~~

~~(1) native Americans;~~

~~(2) family planning services, procedures, drugs, supplies, and devices;~~

~~(3) medicare cross over claims including claims from medicare advantage plans;~~

~~(4) preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc.);~~

~~(5) prenatal and postpartum care and deliveries, and prenatal drug items;~~

~~(6) provider preventable conditions;~~

~~(7) psychotropic drug items are exempt from the brand name co-payment (only the regular pharmacy co-payment applies);~~

~~(8) when the maximum family limit has been exceeded;~~

~~(9) all services rendered by an Indian health services facility (IHS), 638 facility, or urban Indian facility regardless of race code; and~~

~~(10) federal match 3 for categories 071 and 400 through 421 are exempt because these are presumptively eligible children.~~

~~F. Brand name drug: A $3 co-payment for a brand name drug applies to MAD eligible recipients, except for WDI and CHIP, which have higher co-payment amounts, when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.~~

~~G. Non emergent use of the ER: For non emergent use of the ER, the co-payment varies by the federal poverty level (FPL). These co-payment amounts apply to MAD eligible recipients except for WDI which has a higher co-payment amount. The co-payments for non emergent use of the ER are the following:~~

~~(1) $8 if 150 percent of the FPL or below; and~~

~~(2) $50 if greater than 150 percent of the FPL.~~

~~H. The following are exempt from the non emergent use of the ER and brand name drug co-payment:~~

~~(1) native Americans;~~

~~(2) medicare cross over claims including claims from medicare advantage plans;~~

~~(3) psychotropic drug items;~~

~~(4) foster care and adoption categories (Categories 014, 017, 037, 046, 047, 066, and 086); and~~

~~(5) institutional care categories (Categories 081, 083, and 084).~~

~~I. Co-payment maximum: The aggregate amount of cost sharing imposed for all individuals in the family as applied during the quarterly period is five percent of countable family income.~~]

(1) **Children's health insurance program (CHIP) co-payment requirement:** Eligible recipients or members whose benefits are determined using criteria for CHIP are identified by their category of eligibility. The following co-payments apply to CHIP eligible recipients or members:

(a) $2 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $5 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $5 per dental visit, unless all the services are preventive services;

(d) 25 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;

(e) $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

(f) $8 for non-emergent use of the ED.

(2) **Working disabled individual's copayment requirements (WDI):** Eligible recipients or members whose benefits are determined using criteria for WDI are identified by their MAP category of eligibility. The following co-payments apply to WDI eligible

recipients or members:

(a) $3 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $7 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $7 per dental visit, unless all the services are preventive services;

(d) $30 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;

(e) $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

(f) $8 for non-emergent use of the ED.

(E) Co-payment responsibilities: The provider is responsible for understanding and applying the rules for co-payment including when to contact the payer to determine if a co-payment is applicable for the service for the specific eligible recipient or member.

(1) Co-payments are not applied when one or more of the following conditions are met:

(a) the service is a medicare claim or medicare advantage claim, or follows other insurer payment, so the payment is therefore toward a deductible, co-insurance, or co-payment determined by the primary payer;

(b) the eligible recipient or member is a native American;

(c) the service is rendered by an Indian health service (IHS), tribal 638, or urban Indian facility regardless of the race of the eligible recipient or member;

(d) the service is for an eligible recipient enrolled in hospice;

(e) the recipient is under age 21 and has only presumptive eligibility (PE) at the time of service;

(f) the maximum family out-of-pocket cost sharing limit has been reached;

(g) the service was rendered prior to any eligibility being established including when eligibility is retroactively established to the time period of the service;

(h) the eligible recipient or member is in foster care or has an adoption category of eligibility;

(i) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (IID), has a level of care determination or nursing facility care, or other residential care, or for community benefits, or for a home and community-based services waiver;

(j) the service is not for a MAP category of eligibility such as the department of health children's medical services program;

(k) the service is a provider preventable condition or is solely to treat a provider preventable condition; or

(2) the eligible recipient, member or service is exempt from co-payment as otherwise described in these rules.

(3) Other than a co-payment for non-emergent use of the emergency department (ED) or for unnecessary use of a brand name drug, co-payments are not applied when the services are one of the following:

(a) family planning services, procedures drugs, supplies, or devices;

(b) preventive services (well child checks, vaccines, preventive dental cleanings/ exams, periodic health exams) unless treatment is rendered; or

(c) prenatal and postpartum care and deliveries, and prenatal drug items.

(4) Unnecessary use of a brand named drug.

(a) If in the prescriber's estimation, the alternative drug item available on the PDL is either less effective for treating the eligible recipient's condition, or would have more side effects or higher potential for adverse reactions, the co-payment is not applied.

(b) If the prescriber has stated the brand name is medically necessary and therefore the claim is billed with a dispense as written indicator, the co-payment is not applied unless the reason for the brand being medically necessary is something other than the generic form is anticipated to have more side effects or adverse reactions, or would be less effective in treating the eligible recipient

(c) The unnecessary utilization of a brand name drug shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.

(5) Unnecessary use of the ED: the unnecessary utilization of an ED is when an eligible recipient presents to an emergency room for service when the condition of the eligible recipient is not an emergency medical condition and the hospital determines the condition does not require emergency treatment after considering the medical presentation of the eligible recipient, the age of the eligible recipient, alternative providers that may be available in the community at the specific time of day, and other relevant factors. The co-payment is assessed when the eligible recipient is told that the condition does not require emergency treatment and the eligible recipient still choses to continue with the treatment in the ED. A hospital provider must determine the eligible recipient is using the ED for a non-emergent service and apply co-payments to non-emergent use of the ED according to the definition as stated in this paragraph.

[8.200.430.16 NMAC - Rp, 8.200.430.16 NMAC, 1-1-14; A, 10-15-14]

8.200.430.17 RESTITUTION:

A. A [~~medicaid~~] MAP eligible recipient must return overpayments or medical payments received from liable third parties to the applicable medical service provider or to MAD. If payments are not returned or received, recoupment proceedings against the eligible recipient will be initiated.

B. The restitution bureau of HSD is responsible for the tracking and collection of overpayments made to [~~medicaid~~] MAP eligible recipients, vendors, and [~~medicaid~~] MAD providers. See Section OIG-940, RESTITUTIONS. The MAD third party liability unit is responsible for monitoring and collecting payments received from liable third parties. See 8.302.3 NMAC.

[8.200.430.17 NMAC - Rp, 8.200.430.17 NMAC, 1-1-14; A, 10-15-14]

8.200.430.18 [~~ELIGIBLE RECIPIENT RESPONSIBILITY TO ENROLL IN AVAILABLE EMPLOYER-BASED GROUP HEALTH PLAN OR OTHER INSURANCE PLANS:~~ ~~Effective July 01, 1998, HSD no longer accepts referrals to the health insurance premium payment (HIPP) program. HIPP is only available to participants active on HIPP as of July 01, 1998 who have continued to maintain their eligibility for the program. This program will end January 31, 2014.~~]

[8.200.430.18 NMAC - Rp, 8.200.430.18 NMAC, 1-1-14; A, 2-14-14; Repealed, 10-15-14]

[~~8.200.430.19~~] 8.200.430.18 REPORTING REQUIREMENTS: [~~A medicaid~~] An eligible recipient is required to report certain changes which might affect

his or her eligibility. The following changes must be reported to ISD within 10 calendar days from the date the change occurred pursuant to 8.200.400 NMAC, 8.200.410 NMAC, and 8.200.420 NMAC.

A. **Living arrangements or change of address**: Any change in where an eligible recipient lives or gets his or her mail must be reported.

B. **Household size:** Any change in the household size must be reported. This includes the death of an individual included in the either or both the assistance unit and budget group.

C. **Enumeration:** Any new social security number must be reported.

D. **Income:** Except for continuous eligibility in 8.200.400 NMAC any increase or decrease in the amount of income or change in the source of income must be reported.

E. **Resource:** Any change in what an eligible recipient owns must be reported. This includes any property the eligible recipient owns or has interest in, cash on hand, money in banks or credit unions, stocks, bonds, life insurance policies or any other item of value.

[8.200.430.18 NMAC - Rp, 8.200.430.18 NMAC, 1-1-14; A, 2-14-14; 8.200.430.18 NMAC - Rn & A, 8.200.430.19 NMAC, 10-15-14]

[~~8.200.430.20~~] 8.200.430.19 MAD ESTATE RECOVERY: HSD is mandated to seek recovery from the estates of certain individuals up to the amount of medical assistance payments made by the HSD on behalf of the individual. See Social Security Act Section 1917 (42 USC 1396p(b) and NMSA 1978, Section 27-2A-1 et seq. "Medicaid Estate Recovery Act").

A. **Definitions used in MAD estate recovery:**

(1) Authorized representative: The individual designated to represent and act on the eligible recipient's behalf. The eligible recipient or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the member.

[~~(1)~~] (2) Estate: Real and personal property and other assets of an individual subject to probate or administration pursuant to the New Mexico Uniform Probate Code.

[~~(2)~~] (3) Medical assistance: Amounts paid by HSD for long term care services including related hospital and prescription drug services.

[~~(3) Personal representative: An adult designated in writing who is authorized to represent the estate of the eligible recipient.~~]

B. **Basis for defining the group:** A [~~medicaid~~] MAP eligible recipient who was 55 years of age or older when medical assistance payments were made on his or her behalf for nursing facilities services, home and community based services, and related hospital and prescription drug services are subject to estate recovery.

C. **The following exemptions apply to estate recovery:**

(1) Qualified medicare beneficiaries, specified low-income beneficiaries, qualifying individuals, and qualified disabled and working individuals, are exempt from estate recovery for the receipt of hospital and prescription drug services unless they are concurrently in a MAP nursing facility category of eligibility or on a home and community based services waiver; this provision applies to medicare cost-sharing benefits (i.e., Part A and Part B premiums, deductibles, coinsurance, and co-payments) paid under the medicare savings programs.

(2) Certain income, resources, and property are exempted from [~~medicaid~~] MAD estate recovery for native Americans:

(a) interest in and income derived from tribal land and other resources held in trust status and judgment funds from the Indian claims commission and the United States claims court;

(b) ownership interest in trust or non-trust property, including real property and improvements;

(i) located on a reservation or near a reservation as designated and approved by the bureau of Indian affairs of the U.S, department of interior; or

(ii) for any federally-recognized tribe located within the most recent boundaries of a prior federal reservation; and

(iii) protection of non-trust property described in Subparagraphs (a) and (b) is limited to circumstances when it passes from a native American to one or more relatives, including native Americans not enrolled as members of a tribe and non-native Americans such as a spouse and step-children, that their culture would nevertheless protect as family members; to a tribe or tribal organization; or to one or more native Americans;

(c) income left as a remainder in an estate derived from property protected in Paragraph (2) above, that was either collected by a native American, or by a tribe or tribal organization and distributed to native Americans that the individual can clearly trace the income as coming from the protected property;

(d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally-protected rights, and income either collected by [~~an Indian~~] a native American, or by a tribe or tribal organization and distributed to native Americans derived from these sources as long as the individual can clearly trace the ownership interest as coming from protected sources; and

(e) ownership interest in or usage of rights to items, not covered by Subparagraphs (a) through (d) above, that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

D. **Recovery process:** Recovery from an eligible recipient's estate will be made only after the death of the eligible recipient's surviving spouse, if any, and only at a time that the eligible recipient does not have surviving child who is less than 21 years of age, blind, or who meet the SSA definition of disability.

(1) Estate recovery is limited to payments for applicable services received on or after October 1, 1993; except that recovery also is permitted for pre-October 1993 payments for nursing facility services received by a [~~medicaid~~] MAP recipient who was 65 years of age or older when such nursing facility services were received.

(2) A recovery notice will be mailed to the [~~personal~~] authorized representative or next of kin upon the eligible recipient's death informing him or her about the amount of claim against the estate and provide information on hardship waivers and hearing rights.

(3) It is the family or [~~personal~~] authorized representative's responsibility to report the eligible recipient's date of death to the ISD office within 10 calendar days after the date of death.

E. **Eligible recipient rights and responsibilities:**

(1) At the time of application or re-certification, [~~a personal~~] the authorized representative must be identified or confirmed by the applicant or

eligible recipient or his or her designee.

(2) Information explaining estate recovery will be furnished to the applicant or eligible recipient, his or her personal representative, or designee during the application or re-certification process. Upon the death of the [~~medicaid~~] MAP eligible recipient, a notice of intent to collect (recovery) letter will be mailed to the eligible recipient's personal representative with the total amount of claims paid by [~~medicaid~~] MAD on behalf of the eligible recipient. The [~~personal~~] authorized representative must acknowledge receipt of this letter in the manner prescribed in the letter within 30 calendar days of the date on the letter.

(3) During the application or re-certification process for [~~medicaid~~] MAP eligibility, the local county ISD office will identify the assets of an applicant or the eligible recipient. This includes all real and personal property which belongs in whole or in part to the applicant or eligible recipient and the current fair market value of each asset. Any known encumbrances on the asset should be identified at this time by the applicant or the eligible recipient or his or her [~~personal~~] authorized representative.

(4) MAD, or its designee, will send notice of recovery to the probate court, when applicable, and to the eligible recipient's [~~personal~~] authorized representative or successor in interest. The notice will contain the following information:

(a) statement describing the action MAD, or its designee, intends to take;

(b) reasons for the intended action;

(c) statutory authority for the action;

(d) amount to be recovered;

(e) opportunity to apply for the undue hardship waiver;

(f) procedures for applying for a hardship waiver and the relevant timeframes involved;

(g) explanation of the eligible recipient's personal representative's right to request [~~an~~] a HSD administrative hearing; and

(h) the method by which an affected person may obtain a HSD administrative hearing and the applicable timeframes involved.

(5) Once notified by MAD, or its designee, of the decision to seek recovery, it is the responsibility of the eligible recipient's [~~personal~~] authorized representative or successor in interest to notify other individuals who would be affected by the proposed recovery.

(6) The [~~personal~~] authorized representative will:

(a) remit the amount of medical assistance payments to HSD or its designee;

(b) apply for an undue hardship waiver; (see Paragraph (2) of Subsection F below); or

(c) request an administrative hearing.

F. **Waivers:**

(1) For a general waiver, HSD may compromise, settle, or waive recovery pursuant to the Medicaid Estate Recovery Act if it deems that such action is in the best interest of the state or federal government.

(2) Hardship provision: HSD, or its designee, may waive recovery because recovery would work an undue hardship on the heirs. The following are deemed to be causes for hardship:

(a) the deceased recipient's heir would become eligible for a needs-based assistance program such as medicaid or temporary assistance to needy families (TANF) or be put at risk of serious deprivation without the receipt of the proceeds of the estate;

(b) the deceased eligible recipient's heir would be able to discontinue reliance on a needs-based program (such as medicaid or TANF) if he or she received the inheritance from the estate;

(c) the deceased recipient's assets which are subject to recovery are the sole income source for the heir;

(d) the homestead is worth 50 percent or less than the average price of a home in the county where the home is located based on census data compared to the property tax value of the home; or

(e) there are other compelling circumstances as determined by HSD or its designee.

[8.200.430.19 NMAC - N, 1-1-14; 8.200.430.19 NMAC - Rn & A, 8.200.430.20, 10-15-14]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.243.600 NMAC, Sections 3, 6, 8-10 and 12-14, effective October 15, 2014.

8.243.600.3 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 by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).~~] The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq NMSA 1978.

[8.243.600.3 NMAC - N, 1-1-01; A, 10-15-14]

8.243.600.6 OBJECTIVE: The objective of these [~~regulations~~] rules is to provide eligibility policy and procedures for the [~~medicaid program~~] medical assistance programs.

[8.243.600.6 NMAC - N, 1-1-01; A, 10-15-14]

8.243.600.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.243.600.8 NMAC - N, 10-15-14]

8.243.600.9 GENERAL BENEFIT DESCRIPTION: [~~An individual who is eligible for medicaid coverage under the working disabled individuals program is eligible to receive the full range of medicaid covered services~~

~~A. **Co-payment responsibility for WDI recipients:** Eligible recipients have co-payment requirements as follows:~~

~~(1) $5 per prescription, applies to covered prescription and non-prescription drug items;~~

~~(2) $7 per dental visit;~~

~~(3) $7 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session;~~

~~(4) $20 per emergency room visit;~~

~~(5) $30 per inpatient hospital admission.~~

~~B. **Co-payment maximum:**~~

~~(1) The co-payment maximum varies depending on the recipient's income. Once the recipient has reached his/her co-payment maximum on covered medicaid services, co-payments cease for the rest of that calendar year, only after the recipient has fulfilled the required steps listed below.~~

~~(2) Co-payment maximum amounts for WDI recipients are calculated at initial determination, based on the income received in the first month of eligibility, and every twelve months thereafter. The co-payment

~~maximum amount calculated at the initial determination is prorated for the rest of the calendar year and is also determined for the following calendar year. At each annual periodic review, the co-payment maximum will be calculated for the following calendar year.~~

~~(a) Recipients with earned and unearned income below 100% FPL - maximum is $600.~~

~~(b) Recipients with earned and unearned income between 100-250% FPL - maximum is $1500.~~

~~(3) It is the responsibility of the recipient to track and total the co-payments paid.~~

~~(4) Once the yearly maximum amount has been paid on co-payment for medicaid covered services, the recipient must notify the medical assistance division that the maximum amount has been met~~

~~(5) Verification must be provided to the medical assistance division that the co-payment maximum has been paid.~~

~~(6) The first month that co-payments will no longer be required by the WDI recipient is the month following the month in which it has been verified by the medical assistance division that the maximum amount has been met.~~

~~(7) If the determination is made after the twenty-fifth (25th) of the month, the change is made effective the second month after the request.~~

~~(8) No retroactive eligibility for the "met co-payment maximum" criteria is allowed.~~] An individual who meets a medical assistance programs (MAP) category of eligibility for the working disabled individual program (WDI) is eligible to receive full state plan benefits.
[8.243.600.9 NMAC - N, 1-1-01; A, 1-1-02; A, 6-1-04; A, 12-15-04; A, 10-15-14]

8.243.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within [~~sixty~~] 60 days of the date of application. Individuals will have time limits explained, and be informed of the date by which the application should be processed.
[8.243.600.10 NMAC - N, 1-1-01; A, 10-15-14]

8.243.600.12 ONGOING BENEFITS: A re-determination of MAP eligibility is made every [~~twelve~~] 12 months or at such time the MAP eligible recipient begins receiving medicare benefits. Services provided may be subject to cost sharing requirements. Please see 8.302.2 NMAC for more information on any required recipient co-payments.
[8.243.600.12 NMAC - N, 1-1-01; A, 6-1-04; A, 10-15-14]

8.243.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three [~~(3)~~] months of retroactive [~~medicaid coverage~~] MAP eligibility can be furnished to applicants who have received [~~medicaid-covered~~] MAD services during the retroactive period and would have met applicable eligibility criteria had they applied during the three [~~(3)~~] months prior to the month of application. There is no retroactive [~~medicaid coverage~~] MAP eligibility prior to WDI program implementation.

A. **Application for retroactive benefit coverage:** Application for retroactive [~~medicaid~~] MAP eligibility is made by indicating the existence of medical expenses in the three [~~(3)~~] months prior to the month of application on the [~~medicaid~~] MAP application form.

B. **Approval requirements:** To establish retroactive MAP eligibility, verification must be provided to demonstrate that all conditions of eligibility were met for each of the three [~~(3)~~] retroactive months, and that the individual received [~~medicaid-covered~~] MAD services. Eligibility for each month is approved or denied on its own merits.

C. **Disability determination required:** If a disability determination is needed for the date of onset of blindness or disability, a referral will be made to the disability determination contractor.

D. **Notice:**

(1) **Notice to applicant:** The applicant must be informed of the disposition of each retroactive month.

(2) [~~**Recipient**~~] **MAP eligible recipient responsibility to notify provider:** After the retroactive MAP eligibility has been established, the MAP eligible recipient is responsible for informing all MAD providers with outstanding bills of the retroactive MAP eligibility determination. If the individual does not inform all MAD providers and furnish verification of MAP eligibility which can be used for billing, and the MAD provider consequently does not submit the billing within [~~120~~] 90 calendar days from the date of approval of retroactive [~~coverage~~] MAP eligibility, the [~~individual~~] MAP eligible recipient is responsible for payment of the bill.
[8.243.600.13 NMAC - N, 1-1-01; A, 10-15-14]

8.243.600.14 CHANGES IN ELIGIBILITY: A case is closed, with provision of advance notice, when the MAP eligible recipient becomes ineligible. If a MAP eligible recipient dies, the case is closed the following month.
[8.243.600.14 NMAC - N, 1-1-01; A, 10-15-14]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.302.2 NMAC, Sections 3, 7, 9 through 14, effective October 15, 2014.

8.302.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services (HHS) under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.302.2.3 NMAC - Rp, 8.302.2.3 NMAC, 1-1-14; A, 10-15-14]

8.302.2.7 DEFINITIONS:

A. "Authorized representative" means the individual designated to represent and act on behalf of the eligible recipient or member's behalf. The member or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the eligible recipient or member.

B. "Eligible recipient" means an individual who has met a medical assistance program (MAP) category of eligibility and receives his or her medical assistance division (MAD) services through the fee-for-service (FFS) program.

C. "Member" means a MAP eligible recipient and who receives his or her MAD services through a HSD contracted managed care organization (MCO).
[8.302.2.7 NMAC - N, 10-15-14]

8.302.2.9 BILLING FOR MEDICAID SERVICES: Health care for New Mexico [~~medical assistance division (MAD)~~] medical assistance program MAP eligible recipients and members is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD.

Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, utilization review (UR) instructions, and other pertinent material. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. MAD makes available on the MAD website, on other program specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, UR instructions, and other pertinent material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, rules, billing instructions and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. See 8.308.14 NMAC for additional MCO provider responsibilities.

[8.302.2.9 NMAC - Rp, 8.302.2.9 NMAC, 1-1-14; A, 10-15-14]

8.302.2.10 BILLING INFORMATION:

A. **Billing for services:** MAD only makes payment to a provider or to the following individuals or organizations for services:

(1) a government agency or third party with a court order, based on a valid provider payment assignment; see 42 CFR Section 447.10(d)(e); or

(2) a business agent, such as billing service or accounting firm that provides statements and receives payment in the name of the provider; the agent's compensation must be related to the cost of processing the claims and not based on a percentage of the amount that is billed or collected or dependent upon collection of the payment.

B. **Billing for services from group practitioners or employers of practitioners:** MAD may make payments to a group practice and to an employer of an individual practitioner if the practitioner is required to turn over his fees to the employer as a condition of employment. See 42 CFR 447.10(g) (2) (3). MAD may make payments to a facility where the services are furnished or to a foundation, plan, or similar organization operating as an organized health care delivery system if the facility, foundation, plan, or organization is required by contract to submit claims for an individual practitioner.

C. **Billing for referral services:** A referring provider must submit to the provider receiving the referral, specimen, image, or other record, all information necessary for the provider rendering the service to bill MAD within specified time limits. An eligible recipient or their authorized representative or MAD is not responsible for payment if the provider rendering the service fails to obtain this information from the referring provider. Ordering, referring, prescribing, rendering and attending providers must participate in a [~~medicaid managed care plan~~] MCO or the [~~medicaid~~] MAD [~~fee for service~~] (FFS) program, or otherwise be identifiable as a participating, out-of-network, or in-network provider for services, as determined by MAD.

D. **Hospital-based services:** For services that are hospital based, the hospital must provide [~~MAD~~] MAP recipient eligibility and billing information to providers of services within the hospital, including professional components, hospital emergency room (ER) physicians, hospital anesthesiologists, and other practitioners for whom the hospital performs admission, patient registration, or the patient intake process. An eligible recipient, member or his or her [~~their~~] authorized representative, or MAD is not responsible for payment if the hospital-based provider does not obtain this information from the hospital as necessary to bill within the specified time limits.

E. **Coordinated service contractors:** Some MAD services are managed by a coordinated service contractor. Contracted services may include behavioral health services, dental services, physical health services, transportation, pharmacy or other benefits as designated by the MAD. The coordinated service contractor may be responsible for any or all aspects of program management, prior authorization, (UR), claims processing, and issuance of remittance advices and payments. A provider must submit claims to the appropriate coordinated service contractor as directed by MAD.

F. **Reporting of service units:** A provider must correctly report service units.

(1) For current procedural terminology (CPT) codes or healthcare common procedural coding system (HCPCS) codes that describe how units associated with time should be billed, providers are to follow those instructions.

(2) For CPT or HCPCS for services for which the provider is to bill 1 unit per 15 minute or per hour of service, the provider must follow the chart below when the time spent is not exactly 15 minutes or one hour.

time spent	**number of 15-minute units that may be billed**	**number of 1-hour units that may be billed**
Less than 8 minutes	0 *services that are in their entirety less than 8 minutes cannot be billed.*	0 *services that are in their entirety less than 8 minutes cannot be billed.*
8 minutes through 22 minutes	1	.25
23 minutes through 37 minutes	2	.5
38 minutes through 52 minutes	3	.75
53 minutes through 67 minutes	4	1
68 minutes through 82 minutes	5	1.25
83 minutes through 97 minutes	6	1.5

(3) Only time spent directly working with an eligible recipient or member to deliver treatment services is counted toward the time codes.

(4) Total time spent delivering each service using a timed code must be recorded in the medical record of each eligible recipient or member. If services provided are appropriately described by using more than one CPT or HCPCS code within a single calendar day, then the total number of units that can be billed is limited to the total treatment time. Providers must assign the most units to the treatment that took the most time.

(5) The units for codes do not take precedence over [~~CMS's~~] centers for medicare and medicaid services (CMS) national correct coding initiative (NCCI).

(6) Anesthesia units must be billed according to [~~8.310.5~~] 8.310.3 NMAC.

(7) Units billed by a home and community-based services waiver provider, a behavioral health provider, an early intervention provider, and all rehabilitation services providers must also follow the requirements of this section unless exceptions are specifically stated in published MAD program rules or provider billing instructions.

G. **Applying co-payments:** MAD has established co-payments for specified groups of eligible recipients and members for specific services. Exemptions and limits apply to the collection of co-payments.

(1) **Provider responsibilities for collection of co-payments:**

(a) The professional provider is responsible for collecting any applicable co-payments due for any outpatient visit or service provided, including a physician, other practitioner, clinic, urgent care, dental, outpatient therapy, or behavioral health session or visit.

(b) The hospital provider is responsible for collecting any applicable co-payments due for any emergency department (ED) or inpatient services provided.

(i) In the situation where there has been a non-emergent use of the ED by an eligible recipient or member, the hospital is responsible for determining if there is a co-payment due and, if so, collecting the co-payment. Before assessing a co-payment for non-emergent use of the ED, a hospital must consider the medical needs of the eligible recipient or member to judge whether care is needed immediately or if a short delay in treatment would be medically acceptable and any particular challenges the eligible recipient or member may face in accessing follow-up care, such as leave from employment, child care, ability to receive language assistance services, or accessible care for people with disabilities.

(ii) Before assessing a co-payment for non-emergent use of the ED, hospitals must first provide the eligible recipient or member with the name and location of an available and accessible provider that can provide the service at lesser or no cost sharing and provide a referral to coordinate scheduling for treatment by an alternative provider. If geographical or other circumstances prevent the hospital from meeting this requirement, the co-payment may not be imposed. If the eligible recipient or member chooses to receive services from the alternative provider, the co-payment may not be assessed. If, after being advised of the available alternative provider and of the amount of the co-payment due, the eligible recipient or member chooses to continue to receive treatment for a non-emergent condition at the hospital's ED, the hospital shall then assess and collect the co-payment.

(c) The pharmacy is responsible for collecting any co-payments due for drug items dispensed.

(i) When a brand name drug is prescribed, the co-payment for unnecessary use of a brand name drug does not apply when the brand name drug is medically necessary because the available therapeutically equivalent generic alternative would be less effective for treating the eligible [~~recipient's~~] recipient or member's condition, would have more side effects, or a higher potential for adverse reactions exists. If there is no medical justification for the use of the brand name drug, the co-payment for unnecessary use of a brand name drug applies and is collected by the pharmacy.

(ii) If the prescriber has stated that the brand name drug is medically necessary on the prescription and the claim is billed with a dispense as written indicator, the co-payment cannot be applied unless the pharmacy ascertains that the reason for the brand name drug is something other than the medical necessity. This co-payment does not apply to psychotropic drugs. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.

(d) The provider may not deny covered care or services to an eligible recipient or member because of the eligible [~~recipient's~~] recipient or member's inability to pay the co-payment amount at the time of service. The eligible recipient or member remains liable for the co-payment. The provider may attempt to collect the co-payment amount at a later appointment or by billing the eligible recipient or member.

(e) After an eligible [~~recipient's~~] recipient or member's assistance unit has reached the maximum out-of-pocket cost sharing limit (five percent of the eligible [~~recipient's~~] recipient or member's family's income, calculated on a quarterly basis), a provider shall reimburse any co-payments that it has collected from the eligible recipient or member in excess of the maximum out-of-pocket cost sharing limit. This includes anytime a provider receives a remittance advice indicating that the co-payment was not deducted from the reimbursement.

(f) A provider is required to report the co-payment amount charged on the CMS-1500, UB, or pharmacy claim form or their corresponding electronic billing transactions.

(g) [~~A provider shall accept the amounts paid by MAD or the MAD contracted managed care organization (MCO plus any applicable co-payment as payment in full.~~] When a co-payment is applied to a claim, a provider shall accept the amounts paid by MAD or the MCO plus the applicable co-payment as payment in full.

(h) A provider may not impose more than one type of cost sharing for any service.

(2) **Provider to understand the application of co-payments:** The provider is responsible for understanding and applying the rules for co-payment including when to contact the payer to determine if a co-payment is applicable for the service for the specific eligible recipient or member.

(a) Co-payments are not applied when one or more of the following conditions are met:

(i) the service is a medicare claim or medicare advantage claim, or follows other insurer payment, so the payment is therefore toward a deductible, co-insurance, or co-payment determined by the primary payer;

(ii) the eligible recipient or member is a native American;

(iii) the service is rendered by an Indian health service (IHS), tribal 638, or urban Indian facility regardless of the race of the eligible recipient or member;

(iv) [~~the service is a provider preventable condition or is solely to treat a provider preventable condition~~] the service is for an

eligible recipient enrolled in hospice;

(v) the recipient is under age 21 and has only presumptive eligibility (PE) at the time of service;

(vi) the maximum family out-of-pocket cost sharing limit has been reached;

(vii) the service was rendered prior to any eligibility being established including when eligibility is retroactively established to the time period of the service;

(viii) [~~the recipient or service is exempt from co-payment as otherwise described in these rules.~~] the eligible recipient or member is in foster care or has an adoption category of eligibility;

(ix) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (IID), has a level of care determination or nursing facility care, or other residential care, or for community benefits, or for a home and community-based services waiver;

(x) the service is not for a MAP category of eligibility such as the department of health children's medical services program;

(xi) the service is a provider preventable condition or is solely to treat a provider preventable condition; or

(xii) the eligible recipient, member or service is exempt from co-payment as otherwise described in these rules.

(b) Other than a co-payment for non-emergent use of the ED or for unnecessary use of a brand name drug, co-payments are not applied when the services are one of the following:

(i) family planning services, procedures drugs, supplies, or devices;

(ii) preventive services (well child checks, vaccines, preventive dental cleanings/ exams, periodic health exams) unless treatment is rendered; or

(iii) prenatal and postpartum care and deliveries, and prenatal drug items.

(c) [~~A hospital provider must determine the recipient is using the ED for a non-emergent service and apply co-payments to non-emergent use of the ED if necessary~~] Unnecessary use of a brand named drug: the unnecessary utilization of a brand name drug means using a brand name drug that is not on the first tier of a preferred drug list (PDL) instead of an alternative lesser expensive drug item that is on the first tier of a PDL, unless in the prescriber's estimation, the alternative drug item available on the PDL would be less effective for treating the eligible recipient's condition, or would likely have more side effects or a higher potential for adverse reactions for the eligible recipient.

(i) If in the prescriber's estimation, the alternative drug item available on the PDL is either less effective for treating the eligible recipient's condition, or would have more side effects or higher potential for adverse reactions, the cop-payment is not applied.

(ii) If the prescriber has stated the brand name is medically necessary and therefore the claim is billed with a dispense as written indicator, the co-payment is not applied unless the reason for the brand being medically necessary is something other than the generic form is anticipated to have more side effects or adverse reactions, or would be less effective in treating the eligible recipient.

(iii) The unnecessary utilization of a brand name drug shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.

(d) Unnecessary use of the ED: the unnecessary utilization of an ED is when an eligible recipient presents to an emergency room for service when the condition of the eligible recipient is not an emergency medical condition and the hospital determines the condition does not require emergency treatment after considering the medical presentation of the eligible recipient, the age of the eligible recipient, alternative providers that may be available in the community at the specific time of day, and other relevant factors. The co-payment is assessed when the eligible recipient is told that the condition does not require emergency treatment and the eligible recipient still choses to continue with the treatment in the ED. A hospital provider must determine the eligible recipient is using the ED for a non-emergent service and apply co-payments to non-emergent use of the ED according to the definition as stated in this paragraph.

(3) **Payment of claims with applicable co-payment:**

(a) Payment to the provider will be reduced by the amount of an eligible [~~recipient's~~] recipient or member's applicable cost sharing obligation, regardless of whether the provider has collected the payment, unless the uncollected co-payment is for non-emergent use of the ED.

(b) A provider may not adopt a policy of waiving all [~~MAP~~] MAD co-payments or use such a policy to promote his or her practice.

(4) **Children's health insurance program (CHIP) co-payment requirement:** Eligible recipients or members whose benefits are determined using criteria for CHIP are identified by their category of eligibility. The following co-payments apply to CHIP eligible recipients or members:

(a) $2 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $5 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $5 per dental visit, unless all the services are preventive services;

[~~(d) $15 per ED visit, unless a copayment for non-emergent use of the ED is assessed or if the eligible recipient or member is admitted as an inpatient in which case the inpatient hospital co-payment applies;~~]

[~~(e)~~] (d) $25 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;

[~~(f)~~] (e) [~~$5~~] $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

[~~(g)~~] (f) [~~$50~~]$8 for non-emergent use of the ED.

(5) **Working disabled individual's copayment requirements (WDI):** Eligible recipients or members whose benefits are determined using criteria for WDI are identified by their category of eligibility. The following co-payments apply to WDI eligible recipients or members:

(a) [~~$5~~] $3 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;

(b) $7 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;

(c) $7 per dental visit, unless all the services are preventive services;

[~~(d) $20 per ED visit, unless a co-payment for non-emergent use of the ED is assessed or if the eligible recipient is admitted as an inpatient in which case the inpatient hospital co-payment applies;~~]

[~~(e)~~] (d) $30 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;

[~~(f)~~] (e) [~~$8~~] $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and

[~~(g)~~] (f) [~~$28~~] $8 for non-emergent use of the ED.

[~~(6) **Alternative benefit plan (ABP) co-payment requirements for federal poverty level (FPL) less than or equal to 100 percent and for ABP exempt recipients:** [When an eligible recipient's benefits are determined using criteria for ABP are identified by their category of eligibility and are at an FPL less than or equal to 100 percent or ABP exempt recipients, no co-payments apply except for unnecessary services. The following co-payments apply to these ABP eligible recipients:~~

~~(a) $3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and~~

~~(b) $8 for non-emergent use of the ED.~~

~~(7) **Alternative benefit plan co-payment requirements for FPL between 101 and 138 percent:** When eligible recipient's benefits are determined using criteria for ABP are those identified by their category of eligibility and at an FPL between 101 and 138 percent co-payments do apply. The following co-payments apply to these ABP eligible recipients:~~

~~(a) $3 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;~~

~~(b) $8 per outpatient physician or other practitioner, dental visit, rehabilitative or habilitative therapy session (does not apply to ER facility or ER professional charges; does apply to outpatient hospital clinic visits and urgent care visits, but is applied to the professional service, not the facility charge);~~

~~(c) $8 per dental visit, unless all the services are preventive services;~~

~~(d) $25 per inpatient hospital admission unless the hospital is receiving the recipient as a transfer from another hospital;~~

~~(e) $8 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply;~~

~~(f) $8 for non-emergent use of the ED; and~~

~~(g) a co-payment does not apply to exempt services meeting the definition at section 1932(b)(2) of the social security act and 42 CFR section 438.114 [a]), unless the co-payment is for non-emergent use of the ED or for unnecessary use of a brand name drug, including:~~

~~(i) conditions described in Paragraph (2), Subsection G of this section;~~

~~(ii) services for eligible recipients enrolled in hospice;~~

~~(iii) behavioral health and substance abuse services;~~

~~(iv) psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision);~~

~~(v) recipients who have a disability type code of MH or PH on his or her eligibility file; and~~

~~(vi) emergency services.~~]

[~~(8)~~] (6) **All other MAD eligible recipients and members:** Providers shall charge the following co-payment amounts on other MAP eligible recipients or members only in the event of a non-emergent use of the ED or unnecessary uses of a brand name drug. No other co-payments apply.

[~~(a) $3 for unnecessary use of a brand name drug;~~

~~(b) $8 for non-emergent use of the ED if the eligible recipient or member has an income of less than or equal to 150 percent of FPL;~~

~~(c) $50 for non-emergent use of the ED if the eligible recipient or member has an income over 150 percent of FPL;~~

~~(d) no co-payment is applied when the claim is for a co-insurance, deductable deducible or co-payment following payment from a primary payer, including medicare;~~

~~(e) no co-payment is applied when the service is rendered at an IHS, tribal 638, or urban Indian facility;~~

~~(f) the provider shall not charge these co-payments when:~~

~~(i) the eligible recipient or member is native American;~~

~~(ii) the eligible recipient or member is in foster care or has an adoption category of eligibility;~~

~~(iii) the eligible recipient or member does not have a MAP category of eligibility such as being eligible only for the department of health children's medical services program; or~~

~~(iv) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (ID) and has an institutional care category of eligibility.~~

~~H. For purposes of this section, FPL meant means the poverty guidelines updated periodically in the federal register by the U.S. department of health and human services HHS under the authority of 42 U.S.C. 9902(2).~~] (a) $8 for non-emergent use of the ED;

(b) $3 per prescription for the unnecessary use of a brand name drug;

(c) unless the co-payment is for non-emergent use of the ED and the unnecessary use of a brand name drug, the co-payment does not apply to services meeting the definition at section 1932(b)(2) of the Social Security Act and 42 CFR section 438.114 [a]); and

(d) The co-payment for non-emergent use of the ED and for unnecessary use of a brand name drug does not apply to conditions described in Paragraph (2), Subsection G of this section.

[~~I~~] H. **Billing state gross receipts tax:** For providers subject, and registered to pay, gross receipts tax [~~and registered to pay gross receipts tax~~], the provider may include gross receipt tax in the billed amount when the tax applies to the item or service. The provider may only bill tax to the extent the tax is also charged to the general public. A provider may not include gross receipts tax in the billed amount when the provider is not obligated to pay gross receipts tax to the state. [8.302.2.10 NMAC - Rp, 8.302.2.10 NMAC, 1-1-14; A, 10-15-14]

8.302.2.11 BILLING AND CLAIMS FILING LIMITATIONS:

A. Claims must be received within the MAD filing limits as determined by the date of receipt by MAD or its selected claims processing contractor.

(1) Claims for services must be received within 90 calendar days of the date of service unless an alternative filing limit is stated within this section.

(2) Inpatient hospital and other inpatient facility claims must be received within 90 calendar days of the date of the eligible [~~recipient's~~] recipient or member's discharge, transfer, or otherwise leaving the facility.

(3) When the provider can document that a claim was filed with another primary payer including medicare, [~~medicaid managed care organizations~~] a HSD contracted MCO, medicare replacement plans, or another insurer, the claim must be received within 90 calendar days of the date the other payer paid or denied the claim as reported on the explanation of benefits or remittance advice of the other payer, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit the claim to another primary payer within a sufficient timeframe to reasonably allow the primary payer to complete the processing of the claim and also meet the MAD timely filing limit. Denials by the primary payer due to the provider not meeting administrative requirements in filing the claim must be appealed by the provider to the primary payer. [~~The MAD program~~] MAD only considers payment for a claim denied by the other primary payer when under the primary payer's plan the [~~MAD~~] eligible recipient or member is not eligible, the diagnosis, service or item is not within the scope of the benefits, benefits are exhausted, pre-existing conditions are not covered, or out-of-pocket expenses or the deductibles have not been met. MAD will evaluate a claim for further payment including payment toward a deductible, co-insurance, co-payment or other patient responsibility. Claims for payment towards a deductible, co-insurance, co-payment or other patient responsibility also must be received within 90 calendar days of the date of the other payer's payment, not to exceed 210 calendar days from the date of service.

(4) For an eligible recipient or member for whom MAD benefits were not established at the time of service but retroactive eligibility has subsequently been established, claims must be received within [~~120~~] 90 calendar days of the date the eligibility was added to the eligibility record of MAD or its selected claims processing contractor.

(5) For a provider of services not enrolled as a MAD provider at the time the services were rendered, including a provider that is in the process of purchasing an enrolled MAD provider entity such as a practice or facility, claims must be received within 90 calendar days of the date the provider is notified of the MAD approval of the PPA, not to exceed 210 calendar days from the date of service. It is the provider's responsibility to submit a PPA within a sufficient timeframe to allow completion of the provider enrollment process and submission of the claim within the MAD timely filing limit.

(6) For claims that were originally paid by a [~~medicaid~~] HSD contracted MCO from which the capitation payment is recouped resulting in recoupment of a provider's claim by the MCO, the claim must be received within 90 calendar days of the recoupment from the provider.

(7) For claims that were originally paid by MAD or its selected claims processing contractor and subsequently recouped by MAD or its selected claims processing contractor due to certain claims conflicts such as overlapping duplicate claims, a corrected claim subsequently submitted by the provider must be received within 90 calendar days of the recoupment.

B. The provider is responsible for submitting the claim timely, for tracking the status of the claim and determining the need to resubmit the claim.

(1) Filing limits are not waived by MAD due to the providers inadequate understanding of the filing limit requirements or insufficient staff to file the claim timely or failure to track pending claims, returns, denials, and payments in order to resubmit the claim or request an adjustment within the specified timely filing limitation.

(2) A provider must follow up on claims that have been transmitted electronically or hard copy in sufficient time to resubmit a claim within the filing limit in the event that a claim is not received by MAD or its selected claims processing contractor. It is the provider's responsibility to re-file an apparently missing claim within the applicable filing limit.

(3) In the event the provider's claim or part of the claim is returned, denied, or paid at an incorrect amount, the provider must resubmit the claim or an adjustment request within 90 calendar days of the date of the return, denial or payment of an incorrect amount, that was submitted in the initial timely filing period. This additional 90 calendar day period is a one-time grace period following the return, denial or mis-payment for a claim that was filed in the initial timely filing period and is based on the remittance advice date or return notice. Additional 90 calendar day grace periods are not allowed. However, within the 90 calendar day grace period the provider may continue to resubmit the claim or adjustment requests until the 90 calendar day grace period has expired.

(4) Adjustments to claims for which the provider feels additional payment is due, or for which the provider desires to change information previously submitted on the claim, the claim or adjustment request with any necessary explanations must be received by MAD or its selected claims processing contractor with the provider using a MAD-approved adjustment format and supplying all necessary information to process the claim within the one-time 90 calendar day allowed grace period.

C. The eligible recipient, member or [~~their~~] his or her authorized representative is responsible for notifying the provider of [~~MAD~~] MAP eligibility or pending eligibility and when retroactive [~~MAD~~] MAP eligibility is received. When any provider including an enrolled provider, a non-enrolled provider, a MCO provider, and an out-of-network provider is informed of a recipient's [~~MAD~~] MAP eligibility, the circumstances under which an eligible recipient, member or [~~their~~] his or her authorized representative can be billed by the provider are limited.

(1) When the provider is unwilling to accept the eligible recipient as a [~~MAD fee-for-service~~] (FFS) eligible recipient or a MCO [~~eligible recipient~~] member, the provider must provide the eligible recipient, member or [~~their~~] his or her authorized representative written notification that they have the right to seek treatment with another provider that does accept [~~MAD~~] a FFS eligible recipient or a MCO [~~eligible recipients~~] member. It is the provider's responsibility to have the eligible recipient, member or [~~their~~] his or her authorized representative receive and sign a statement that they are aware the proposed service may be covered by MAD if rendered by an approved MAD or [~~MAD~~] MCO provider and that by authorizing a non-approved provider to render the service, they agree to be held financially responsible for any payment to that provider. A provider may only bill or accept payment for services from an eligible recipient, member or [~~their~~] his or her authorized representative if all the following requirements are satisfied:

(a) The eligible recipient, member or [~~their~~] his or her authorized representative is advised by the provider before services are furnished that he or she does not accept patients whose medical services are paid for by MAD.

(b) The eligible recipient, member or [~~their~~] his or her authorized representative is advised by the provider regarding the necessity, options, and the estimated charges for the

service, and of the option of going to a provider who accepts MAD payment.

(2) The eligible recipient or member is financially responsible for payment if a provider's claims are denied because of the eligible [~~recipient's~~] recipient, member or [~~their~~] his or her authorized representative's failure to notify the provider of established eligibility or retroactive eligibility in a timely manner sufficient to allow the provider to meet the filing limit for the claim.

(3) [~~When a provider is informed of MAD eligibility or pending MAD eligibility prior to rendering a service, the provider cannot bill the eligible recipient or their authorized representative for the service even if the claim is denied by MAD or its selected claims processing contractor unless the denial is due to the recipient not being eligible for the MAD program or the service or item is not a benefit of the MAD program. In order to bill the eligible recipient for an item or service that is not a benefit of the program. , prior to rendering the service or providing the item the provider must inform the eligible recipient or their authorized representative the service is not covered by the MAD program and obtain a signed statement from the eligible recipient or their authorized representative acknowledging such notice. It is the provider's responsibility to understand or confirm the benefits of the MAD program the benefits and to inform the eligible recipient or their authorized representative when the service is not a benefit of the program and to inform the eligible recipient or their authorized representative.~~] When a provider is informed of MAP eligibility or pending eligibility prior to rendering a benefit, the provider cannot bill the eligible recipient, member or his or her authorized representative for the benefit even if the claim is denied by MAD or its selected claims processing contractor unless the denial is due to the recipient not being eligible for the MAP category of eligibility or the benefit, or item is not a MAD benefit. In order to bill the eligible recipient or member for an item or benefit that is not a MAD benefit, prior to rendering the benefit or providing the item the provider must inform the eligible recipient, member or his or her authorized representative the benefit is not covered by MAD and obtain a signed statement from the eligible recipient, member or his or her authorized representative acknowledging such notice. It is the provider's responsibility to understand or confirm the eligible recipient or member's MAD benefits and to inform the eligible recipient, member or his or her authorized representative when the benefit is not a MAD benefit and to inform the eligible recipient, member or his or her authorized representative.

(4) The provider must accept [~~medicaid~~] MAD payment as payment in full and cannot bill a remaining balance to the eligible recipient, member or [~~their~~] his or her authorized representative other than a MAD allowed copayment, coinsurance or deductible.

(5) If the provider claim is denied, the provider cannot use a statement signed by the eligible recipient, member or [~~their~~] his or her authorized representative to accept responsibility for payment unless such billing is allowed by MAD rules. It is the responsibility of the provider to meet the MAD program requirements for timely filing and other administrative requirements, to provide information to MAD or its selected claims processing contractor regarding payment issues on a claim, and to accept the decision of MAD or its selected claims processing contractor for a claim. The eligible recipient, member or [~~their~~] his or her authorized representative does not become financially responsible when the provider has failed to [~~met~~] meet the timely filing and other administrative requirements in filing a claim. The eligible recipient, member or [~~their~~] his or her authorized representative does not become financially responsible for payment for services or items solely because MAD or its selected claims processing contractor denies payment for a claim.

(6) When a provider has been informed of [~~MAD~~] MAP eligibility or pending [~~MAD~~] eligibility of a recipient, the provider cannot turn an account over to collections or to any other entity intending to collect from the eligible recipient, member or [~~their~~] his or her authorized representative. If a provider has turned an account over for collection, it is the provider's responsibility to retrieve that account from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor and to notify the eligible recipient or member.

D. The filing limit does not apply to overpayments or money being returned to MAD or its selected claims processing contractor.

(1) If a provider receives payment from another source, such as any insurance plan, or other responsible third party, after receiving payment from MAD, an amount equal to the lower of either the insurance payment or the amount paid through [~~the medicaid program~~] MAD must be remitted to MAD or its selected claims processing contractor third party liability unit, properly identifying the claim to which the refund applies.

(2) For claims for which an over-payment was made to the provider, the provider must return the overpayment to MAD or its selected claims processing contractor. For more details see 8.351.2 NMAC. The timely filing provisions for payments and adjustments to claims do not apply when the provider is attempting to return an overpayment.

E. MAD or its selected claims processing contractor may waive the filing limit requirement in the following situations:

(1) An error or delay on the part of MAD or its selected claims processing contractor prevented the claim from being filed correctly within the filing limit period. In considering waiver of a filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim in a timely manner and the follow up efforts made to secure payment in a timely manner from the other payer.

(2) The claim was filed within the filing limit period but the claim is being reprocessed or adjusted for issues not related to the filing limit.

(3) The claim could not be filed timely by the provider because another payer or responsible party could not or did not process the claim timely or provide other information necessary to file the claim timely. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to initially file the claim and to follow up on the payment from another payer or responsible party in order to attempt to meet the MAD filing limit.

(4) An eligible recipient or member for whom [~~MAD~~] MAP or medicare eligibility was established by hearing, appeal, or court order. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the hearing or court decision.

(5) The claim is being reprocessed by MAD or its selected claims processing contractor for issues not related to the provider's submission of the claim. These circumstances may include when MAD is implementing retroactive price changes, or reprocessing the claim for accounting purposes.

(6) The claim was originally paid but recouped by another primary payer. In considering a waiver of the filing limit for a claim for this situation, MAD or its selected claims processing contractor will consider the efforts made by the provider to file the claim timely after the recoupment.

(7) The claim is from a federal IHS facility operating within [~~the federal department of health and human services~~] HHS which is responsible for native American health care or is a PL 93-638 tribally operated hospital and clinic which must be finalized within two years of the date of service.

(8) The claim is from a [~~medicaid~~] MAD school-based service program when providing services to a [~~MAD~~] eligible recipient or member through an individualized education plan or an individualized family service plan to which an initial filing limit of 90 calendar days is applied.

F. [~~The medicaid program~~] MAD is jointly funded through state and federal sources. Claims will not be processed when the federal standards are not met, thereby precluding federal financial participation in payment of the claim.

G. A provider may not bill an eligible recipient, member or [~~their~~] his or her authorized representative for a service or item when a claim is denied due to provider error in filing the claim or failing to meet the timely filing requirements. It is the provider's responsibility to understand or verify the specific [~~MAD program~~] MAP category of eligibility in which an eligible recipient or member is enrolled, the covered or non-covered status of a service or item, the need for prior authorization for a service or item, and to bill the claim correctly and supply required documentation. The eligible recipient, member or [~~their~~] his or her authorized representative cannot be billed by the provider when a claim is denied because these administrative requirements have not been met.

(1) The provider cannot bill the eligible recipient, member or [~~their~~] his or her authorized representative for a service or item in the event of a denial of the claim unless the denial is due to the recipient not being eligible for the MAD [~~program~~] service; or if the service is not a MAD benefit [~~of the MAD program~~], prior to rendering the service the provider informed the eligible recipient, member or [~~their~~] his or her authorized representative that the specific service is not covered by [~~the MAD program~~] MAD and obtained a signed statement from the eligible recipient, member or [~~their~~] his or her authorized representative acknowledging such.

(2) The provider cannot bill the eligible recipient, member or [~~their~~] his or her authorized representative for the service in the event that a payment is recouped by another primary payer and MAD or its selected claims processing contractor determines that the claim will not be reimbursed by MAD or its selected claims processing contractor.

(3) The provider cannot turn an account over to collections or to any other factor intending to collect from the eligible recipient, member or [~~their~~] his or her authorized representative. If a provider has turned an account over to a collection agency, it is the provider's responsibility to retrieve that account back from the collection agency and to accept the decision on payment of the claim by MAD or its selected claims processing contractor.

(4) The provider cannot bill the eligible recipient, or member or his or her authorized representative for office tasks such as billing claims, checking eligibility, making referrals calls, in the form of either routine charges or as penalties including missed appointments, failure to cancel an appointment, failure to show eligibility card or similar charges unless specifically allowed by MAD rules.

H. When documentation is required to show the provider met applicable filing limits, the date a claim is received by MAD or its selected claims processing contractor will be documented by the date on the claim transaction control number (TCN) as assigned by MAD or its selected claims processing contractor. Documentation of timely filing when another third party payer, including medicare, is involved will be accepted as documented on explanation of benefits payment dates and reason codes from the third party. Documentation may be required to be submitted with the claim.
[8.302.2.11 NMAC - Rp, 8.302.2.11 NMAC, 1-1-14; A, 10-15-14]

8.302.2.12 BILLING FOR DUAL-ELIGIBLE MEDICAID RECIPIENTS: To receive payment for services furnished to [~~a MAD~~] an eligible recipient or member who is also entitled to medicare, a provider must first bill the appropriate medicare payer. The medicare payer pays the medicare covered portion of the bill. After medicare payment, MAD pays the amount the medicare payer determines is owed for copayments, co insurance and deductibles, subject to [~~medicaid~~] MAD reimbursement limitations. If a medically necessary service is excluded from medicare and it is a [~~medicaid~~] MAD covered [~~services~~] benefit, MAD will pay for service. When the medicare payment amount exceeds the amount that MAD would have allowed for the service, no further payment is made for the coinsurance, deductible, or copayment. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare coinsurance, deductible, or copayment from the eligible recipient or their authorized representative. For behavioral health professional services for which medicare part B applies to a "psych reduction" to the provider payment and increases the eligible recipient or member coinsurance rate, medicare coinsurance and deductible amounts are paid at an amount that allows the provider to receive 80 percent of the medicare allowed amount even if such amount exceeds the MAD allowed amount for the service. A provider must accept assignment on medicare claims for MAD eligible recipients and members. A provider who chooses not to participate in medicare or accept assignment on a medicare claim must inform the MAD eligible recipient, member or [~~their~~] his or her authorized representative that the provider is not a medicare provider or will not accept assignment; and because of those provider choices, MAD cannot pay for the service. Additionally, the provider must inform the [~~MAD~~] eligible recipient, member or [~~their~~] his or her authorized representative of the estimated amount for which the eligible recipient or member will be responsible, that service is available from other providers who will accept assignment on a medicare claim, and identify an alternative provider to whom the eligible recipient or member may seek services. The provider cannot bill a dually eligible [~~MAD~~] MAP recipient or member for a service that medicare cannot pay because the provider chooses not to participate in medicare, or which MAD cannot pay because the provider chooses not to accept assignment on a claim, without the expressed consent of the [~~MAD~~] eligible recipient, member or [~~their~~] his or her authorized representative even when the medicare eligibility is established retro-actively and covers the date of service.

A. **Claim crossover:** If there is sufficient information for medicare to identify an individual as a [~~MAD~~] eligible recipient or member, medicare may send payment information directly to the MAD claims processing contractor in a form known as a "cross-over claim". In all cases where claims fail to crossover automatically to MAD, a provider must bill the appropriate MAD claims processing contractor directly, supplying the medicare payment and medicare "explanation of benefits" (EOB) information and meet the MAD filing limit.

B. **Medicare replacement plan or other health maintenance organization (HMO) plan:** When a [~~MAD~~] eligible recipient or member belongs to a medicare replacement plan or HMO, MAD pays the amount the payer determines is owed for copayments, coinsurance or deductible, subject to [~~medicaid~~] MAD reimbursement limitations. When the payer payment amount exceeds the amount that MAD would have allowed for the service, no

further payment is made for the copayment, coinsurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the payer copayment, coinsurance or deductible from the eligible recipient, member or [~~their~~] his or her authorized representative. For behavioral health services for which medicare part B applies to a "psych reduction" to the provider payment and increases the eligible recipient or member coinsurance rate, medicare coinsurance and deductible amounts are paid at the amount that allows the provider to receive up to 80 percent of the payer amount allowed even if the amount exceeds the MAD allowed amount for the services.

C. All other HMO and medicare replacement plan requirements, including provider network restrictions must be met for [~~medicaid~~] MAD to make payment on a claim.

[8.302.2.12 NMAC - Rp, 8.302.2.12 NMAC, 1-1-14; A, 10-15-14]

8.302.2.13 BILLING FOR CONTRACTED SERVICES: MAD only makes payment to a provider who actually rendered the services. However, in the following instances a MAD provider can bill and be paid for covered contracted services.

A. A provider is reimbursed at encounter rates or other all-inclusive rates that may have some contracted services built into those rates. These providers include NF, [~~intermediate care facilities (ICF)-IID~~] ICF-IDD, residential treatment centers, a group home, a hospice agency, a federally qualified health center, a rural health clinic, and an IHS or tribal 638 facility.

B. A practitioner group, a clinic, an institutional professional component, and providers of professional services may bill for services furnished by practitioners under contract when the provider applications are approved by MAD, and the following apply:

(1) the MAD provider participation applications are completed by the billing entity and the practitioner rendering the service or in their employ; and

(2) the practitioner is listed as the rendering provider on the claim form.

C. Transportation providers may bill for contracted personnel, equipment or vehicles.

D. A provider may bill MAD directly for contracted services for the construction or assembly of equipment or prosthetic devices, construction of dental devices and prosthetics, hearing and vision prosthesis, orthotics, and repairs, when:

(1) the provider customarily uses the dental laboratory, optical supplier, hearing aid supplier, prosthetic or orthotic supplier equipment dealer, or manufacturer to do work; and

(2) the contractor doing the work does not qualify as an eligible provider in his or her own right.

E. For all other contracted services not specified above, written prior approval must be obtained from MAD or its designee before the provision of services.

F. **Billing rates for contracted services:** All services provided by a contractor and billed through a participating MAD provider must be billed at a rate based on direct and indirect costs, plus a reasonable administrative charge. The billing provider must ensure all MAD requirements are met by the contractor furnishing the service, including prior approval requirements, if applicable. Reimbursement for contracted services is included in the fee paid to the provider. For example, the amount paid to a dentist for a crown includes the dentist's work fitting the crown and the dental lab fees for making the crown.

G. **Recipient freedom of choice:** A provider cannot enter into contracts that are used to restrict an eligible [~~recipient's~~] recipient or member's freedom of choice. Some restrictions to this freedom of choice may apply to the purchases of medical devices and laboratory and radiology tests, and transportation [42 CFR Section 431.54(e)], or for providers whose enrollment is under a moratorium as identified or approved by the secretary of the federal HHS or by CMS.

[8.302.2.13 NMAC - Rp, 8.302.2.13 NMAC, 1-1-14; A, 10-15-14]

8.302.2.14 BILLING AND PAYMENT LIMITATIONS:

A. **Payment not allowed:** MAD does not pay factors either directly or by power of attorney (42 CFR Section 447.10(h)). A factor is an individual or an organization, such as a collection agency or service bureau.

B. **No reimbursement for the discharge day:** An institutional or other residential provider, such as a NF, a hospital, an ICF-IID, and a provider of treatment foster care services are reimbursed for services furnished to an eligible recipient or member on the day of admission but are not reimbursed for services furnished on day of discharge.

C. **No payment made for wrong services:** A provider shall not bill MAD for:

(1) services provided to the wrong patient;

(2) a service performed on the wrong body part of an eligible recipient or member; and

(3) an incorrect procedure performed on an eligible recipient or member.

D. **Payments for acquired conditions:** MAD may deny or limit payment on claims for services to treat [~~a MAD~~] an eligible recipient or member for a condition acquired during the course of a facility stay or in the rendering of other services.

[8.302.2.14 NMAC - Rp, 8.302.2.14 NMAC, 1-1-14; A, 10-15-14]

NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.308.14 NMAC, Section 7 and 9, effective October 15, 2014.

8.308.14.7 DEFINITIONS:

A. **Co-payment:** A fixed dollar amount that must be paid at the time a MAD service is provided or a prescription is filled.

B. **Emergency medical condition:** A medical or behavioral health condition manifesting itself in acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment of bodily functions;

(3) serious dysfunction of any bodily organ or part; or

(4) serious disfiguration to the member.

C. **Unnecessary utilization of services:**

(1) The unnecessary utilization of a brand name drug means using a brand name drug that is not on the first tier of a preferred drug list (PDL) instead of [~~a~~] an alternative lesser expensive drug item that is on the first tier of a PDL, unless in the prescriber's estimation, the alternative drug item available on the PDL would be less effective for treating the member's condition, or would likely have more side effects or a higher potential for adverse reactions for the member.

(2) [~~The unnecessary utilization of an emergency department (ED) is when a member presents to an emergency room for service when the condition of the member is not an emergency medical condition and considered non-emergent after considering the medical presentation of the member, age, and other factors, but also alternative~~

~~providers that may be available in the community at the specific time of day.~~] The unnecessary utilization of an emergency department (ED) is when a member presents to an emergency room for service when the condition of the member is not an emergency medical condition and the hospital determines the condition does not require emergency treatment after considering the medical presentation of the member, the age of the member, alternative providers that may be available in the community at the specific time of day, and other relevant factors. The co-payment is assessed when the member is told that the condition does not require emergency treatment and the member still choses to continue with the treatment in the ED. [8.308.14.7 NMAC - N, 1-1-14; A, 10-15-14]

8.308.14.9 COST SHARING IN MEDICAID MANAGED CARE PROGRAM: The medical assistance division (MAD) imposes cost-sharing (out-of- pocket) provisions on certain members, certain categories of eligibility and on certain services. Cost-sharing includes co-payments, coinsurance, deductibles, and other similar charges. The member's HSD contracted managed care organization (MCO) is required to impose the following co-payments as directed by MAD and in accordance with federal regulations.

A. **General requirements regarding cost sharing:**

(1) The MCO or its contracted providers may not deny services for a member's failure to pay the co-payment amounts.

(2) The MCO must take measures to educate and train both its contracted providers and members on cost-sharing requirements, and must include, at a minimum:

(a) educating and working with the MCO's hospital providers on the requirements related to non-emergency utilization of the emergency department (ED); and

(b) for co-payments required in the case of a non-emergency utilization of an ED (an unnecessary use of services) the hospital is required, before imposing cost sharing, to provide the member with a name of and location of an available and accessible provider that can provide the service with lesser or no cost sharing and provide a referral to coordinate scheduling; if geographical or other circumstances prevent the hospital from meeting this requirement, the cost sharing may not be imposed.

(3) The MCO shall not impose cost-sharing provisions on certain services that, in accordance with federal regulations, are always exempt from cost-sharing provisions. See CFR 447.56, *Limitations on Premiums and Cost Sharing,* 8.200.430 NMAC and 8.302.2 NMAC.

(4) The MCO shall not impose cost-sharing provisions on certain member [~~populations~~] categories of eligibility that, in accordance with federal and state regulations and rules, are exempt from cost-sharing provisions. The MCO and its contracted providers are required to impose co-payments on its members in the case of unnecessary utilization of specific services as outlined in Subsection B of Section 9 of this rule, unless the [~~eligible recipient~~] member is exempt from the copayments; see Subsection B of Section [~~10~~] 9of this rule.

(5) Payments to MCO contracted providers: In accordance with 42 CFR 447.56, *Limitations on Premiums and Cost Sharing* and New Mexico state statute 27-2-12.16:

(a) the MCO must reduce the payment it makes to a non-hospital contracted provider by the amount of the member's applicable cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing; and

(b) the MCO must not reduce the payment it makes to a contracted hospital provider by the amount of the member's cost sharing obligation if the contracted hospital provider is not able to collect the cost sharing obligation from the member.

(6) At the direction of MAD, the MCO must report all cost-sharing amounts collected.

(7) The MCO may not impose more than one type of cost sharing for any service, in accordance with 42 CFR 447.52.

(8) The MCO must track, by month, all co-payments collected from each individual member in the household family to ensure that the family does not exceed the aggregate limit (cap). The cap is five percent of countable family income for all individual members in a household family calculated as applicable for a quarter. The MCO must be able to provide each member, at his or her request, with information regarding co-payments that have been applied to claims for the member.

(9) The MCO must report to the provider when a copayment has been applied to the provider's claim and when a copayment was not applied to the provider's claim. The MCO shall be responsible for assuring the provider is aware that:

(a) the provider shall be responsible for refunding to the member any copayments the provider collects after the [~~eligible recipient~~] member has reached the co-payment cap (five percent of the [~~eligible recipient's~~] member's family's income, calculated on a quarterly basis) which occurs because the MCO was not able to inform the provider of the exemption from copayment due to the timing of claims processing;

(b) the provider shall be responsible for refunding to the member any copayments the provider collects for which the MCO did not deduct the payment from the provider's payment whether the discrepancy occurs because of provider error or MCO error; and

(c) failure to refund a collected copayment to a member and to accept full payment from the MCO may result in a credible allegation of fraud, see 8.351.2 NMAC.

B. **Unnecessary utilization of services co-payments:** [~~The use of a brand name prescription drug in place of a generic therapeutic equivalent on the PDL and the utilization of the emergency room for non-ED services are both considered to be unnecessary utilization of services. Some members are exempt from copayments for unnecessary utilization of services.~~] For a definition of unnecessary utilization of services, please see Subsection C of 8.308.14.7 NMAC.

(1) Providers shall charge the following co-payment amounts on other MAP eligible recipients or members, including ABP, only in the event of a non-emergent use of the ED or unnecessary uses of a brand name drug. No other co-payments apply.

(a) $3 for unnecessary use of a brand name drug;

(b) $8 for non-emergent use of the ED if the eligible recipient or member;

(c) no co-payment is applied when the claim is for a co-insurance, deductible or co-payment following payment from a primary payer, including medicare;

(d) no co-payment is applied when the service is rendered at an IHS, tribal 638, or urban Indian facility;

(e) the provider shall not charge these co-payments when:

(i) the eligible recipient or member is native American;

(ii) the eligible recipient or member is in foster care or has an adoption category of eligibility;

(iii) the eligible recipient or member does not have a MAP category of eligibility such as being eligible only for the department of health children's medical services program;

or

(iv) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (IID) and has an institutional care category of eligibility.

[~~(1)~~] (2) When a member obtains a brand name prescription drug in place of a generic therapeutic equivalent on his or her MCO's PDL, the MCO and dispensing pharmacy must impose a co-payment in the amount specified by MAD for the member, unless the member is exempt from copayments for unnecessary utilization of services or the use of the drug does not meet the definition for unnecessary utilization of a brand name drug as defined in this section. The MCO is responsible for determining when this unnecessary utilization of service has taken place and if so, the dispensing pharmacy is responsible for collecting the co-payment from the member.

[~~(2) The unnecessary utilization of a brand name drug shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.~~]

(3) The MCO shall develop a co-payment exception process, to be prior approved by MAD, for legend drugs when generic alternatives are not tolerated by a member.

[8.308.14.9 NMAC - N, 1-1-14; A, 6-1-14; A, 10-15-14]

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

This is an amendment to 8.309.4 NMAC, Section 12, effective October 15, 2014.

8.309.4.12 GENERAL ABP COVERED SERVICES:

A. **Ambulatory surgical services:** The benefit package includes surgical services rendered in an ambulatory surgical center setting as detailed in 8.324.10 NMAC.

B. **Anesthesia services:** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures as detailed 8.310.2 NMAC.

C. **Audiology services:** The benefit package includes audiology services as detailed in 8.310.2 and 8.324.5 NMAC with some limitations. For a ABP eligible recipient 21 years and older, audiology services are limited to hearing testing or screening when part of a routine health exam and are not covered as a separate service. Audiologist services, hearing aids and other aids are not covered for an ABP recipient.

D. **ABP eligible recipient transportation:** The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health services for an ABP eligible recipient in or out of his or her home community as detailed in 8.310.2 NMAC.

E. **Dental Services:** The benefit package includes dental services as detailed in 8.310.2 NMAC.

F. **Diagnostic imaging and therapeutic radiology services:** The benefit package includes medically necessary diagnostic imaging and radiology services as detailed in 8.310.2 NMAC.

G. **Dialysis services:** The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. A dialysis provider shall assist an ABP eligible recipient in applying for and pursuing final medicare eligibility determination.

H. **Durable medical equipment and medical supplies:** The benefit package includes:

(1) durable medical equipment as detailed in 8.310.2 NMAC;

(2) covered prosthetic and orthotic services as detailed in 8.310.2 NMAC and 8.324.5 NMAC; and

(3) medical supplies as detailed in 8.310.2 NMAC with some limitations; for an ABP eligible recipient 21 years of age and older the only medical supplies that are covered:

(a) diabetic supplies, such as reagents, test strips, needles, test tapes, and alcohol swabs; and

(b) medical supplies that are a necessary component of durable medical equipment, medical supplies applied as part of a treatment in a practitioner's office, outpatient hospital, residential facility, as a home health service and in other similar settings are covered as part of a service (office visit), which are not reimbursed separately; and

(c) family planning supplies.

I. **Emergency and non-emergency transportation services:** The benefit package includes transportation service such as ground ambulance, or air ambulance in an emergency and when medically necessary, taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services as detailed in 8.324.7 NMAC. Non-emergency transportation is covered only when an ABP eligible recipient does not have a source of transportation available and when the ABP eligible recipient does not have access to alternative free sources. MAD or its UR contractor shall coordinate efforts when providing transportation services for an ABP eligible recipient requiring physical or behavioral health services.

J. **Home health services:** The benefit package for an ABP eligible recipient as detailed in 8.325.9 NMAC with some limitations. For an ABP eligible recipient 21 years of age and older, home health services are limited to 100 visits annually that do not exceed four hours-per-visit.

K. **Hospice services:** The benefit package for an ABP eligible recipient as detailed in 8.325.4 NMAC.

L. **Hospital outpatient service:** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services as detailed in 8.311.2 and 8.321.2 NMAC.

M. **Inpatient hospital services:** The benefit package includes hospital inpatient acute care, procedures and services for the eligible recipient as detailed in 8.311.2 NMAC and inpatient rehabilitation hospitals detailed in 8.311.2 NMAC. [~~Extended care hospitals or acute long term care hospitals are not an ABP benefit.~~] Long-term acute care hospitals (extended care hospitals) are covered only as a temporary step-down level of care (LOC) following the eligible recipient's discharge from a hospital prior to being discharged to home.

N. **Laboratory services:** The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA) as detailed in 8.310.2 NMAC. Additionally, ABP diagnostic testing coverage includes physical measurements and performance testing, such as cardiac stress tests and sleep studies.

O. **Physical health services:** The benefit package includes primary, primary care in a school-based setting, family planning and specialty physical health services provided by a licensed practitioner performed within the scope of practice; see 8.310.2 and 8.310.3 NMAC. Benefits also include:

(1) an out of hospital birth and other related birthing services performed by a certified nurse midwife or a direct-entry midwife licensed by the state of New Mexico, who is either validly contracted with and fully credentialed by or validly contracted with

HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC; and

(2) bariatric surgery is limited to one per lifetime; meeting additional criteria to assure medical necessity may be required prior to accessing services.

P. **Rehabilitation and habilitation services:** The benefit package includes rehabilitative and habilitative services as detailed in 8.323.5 NMAC. For an eligible recipient 21 years and older there are service limitations listed below:

(1) cardiac rehabilitation is limited to 36 visits per cardiac event;

(2) pulmonary rehabilitation is limited to short-term therapy as defined in Paragraph (3) below; and

(3) physical and occupational therapies and speech and language pathology:

(a) are short-term therapies that produce significant and demonstrable improvement within the two-month period of the initial date of treatment; and

(b) the short-term therapy may be extended beyond the initial two month period for one additional period of up to two months dependent upon the MAD UR contractor, only if such services can be expected to result in continued significant improvement of the ABP eligible recipient's physical condition within the extension period.

(4) nursing facility (NF) and acute long term care facility stays only as a temporary step-down LOC from a hospital prior to the eligible recipient's discharge to home.

Q. **Private duty nursing:** For an eligible recipient under 21 years of age, private duty nursing services are covered under EPSDT program. See Section 18 of this rule for a detailed description. For recipients age 21 and older, private duty nursing is only available through the home health benefit. See Subsection J of this section and 8.325.9 NMAC.

R. **Tobacco cessation services:** The benefit package includes cessation sessions as described in 8.310.2 NMAC but is not limited to EPSDT or pregnant women.

S. T**ransplant services:** The following transplants are covered in the benefit package as long as the indications are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants and corneal transplants. For an ABP eligible recipient 21 years or older, there is a lifetime limitation two transplants. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

T. **Vision:** The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for an ABP eligible recipient as detailed in 8.310.2 NMAC. All services must be furnished within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules. For an ABP eligible recipient 21 years or older, the service limitations are:

(1) coverage is limited to one routine eye exam in a 36-month period; and

(2) MAD does not cover refraction or eyeglasses other than for aphakia following removal of the lens. [8.309.4.12 NMAC - N, 1-1-14; A, 10-15-14]

NEW MEXICO RACING COMMISSION

Explanatory paragraph: This is an amendment to 15.2.5 NMAC, Section 13, effective October 15, 2014. In 15.2.5.13 NMAC, Subsection B through E were not published as there were no changes.

15.2.5.13 RUNNING OF THE RACE:

A. EQUIPMENT.

(1) All riding crops are subject to inspection and approval by the stewards and the clerk of scales. This rule will become effective December 10, 2010.

(a) For all thoroughbred races (measured in furlongs) the riding crops shall have a shaft, a flap and will be allowed in flat racing including training. No riding crop shall weigh more than eight ounces nor exceed 30 inches in length, including the shaft. No riding crop shall be used unless the shaft is a minimum of one-half inch in diameter; and the shaft contact area must be smooth, with no protrusions or raised surface and covered by shock absorbing material that gives a compression factor of at least one-millimeter throughout its circumference.

(b) The flap is the only allowable attachment to the shaft and must meet the following specifications. The length beyond the end of the shaft shall be a maximum of one inch with a mimimum width of .08 inch and a maximum of 1.6 inches. There shall be no reinforcements or additions beyond the end of the shaft. There shall be no binding within seven inches of the end of the shaft and the flap must include shock absorbing characteristics similar to those of the contact area of the shaft.

(c) For all quarter horse races (measured in yards) riding crops will be allowed in flat racing including training. No riding crop shall weigh more than one pound nor exceed 31 inches in length, including the popper. No riding crop shall be used unless it has affixed to the end a looped popper not less than one and one-quarter (1 ¼) inches in width, and not over three (3) inches in length, and be feathered above the popper with no less than three (3) rows of feathers, each feather not less than one (1) inch in length. There shall be no holes in the popper.

(2) No bridle shall exceed two pounds.

(3) Reins. No jockey, apprentice jockey, exercise person or any person mounted on a horse shall ride, breeze, exercise, gallop or workout a horse on the grounds of a facility under the jurisdiction of the commission unless the horse is equipped with a nylon rein or a safety rein. A safety rein is a rein with a wire or nylon cord stitched into the traditional leather rein during the manufacturing process and the safety cord is attached to the bit with a metal clasp.

(4) Toe grabs with a height greater than two millimeters worn on the front shoes of thoroughbred horses while racing are prohibited. The horse shall be scratched and the trainer may be subject to fine.

(5) A horse's tongue may be tied down with clean bandages, gauze or tongue strap.

(6) No licensee may add blinkers to a horse's equipment or discontinue their use without the prior approval of the starter, the paddock judge, and the stewards.

(7) No licensee may change any equipment used on a horse in its last race without approval of the paddock judge or stewards.

(8) Any licensed assistant starter and any licensee mounted on a horse or stable pony on the association's racing surface (racetrack surface) must wear a properly fastened New Mexico racing commission approved protective helmet and safety vest. [~~The safety vest worn by a jockey shall weigh no more than two pounds and all vests shall be designed to provide shock-absorbing protection to the upper body of at least a rating of five, as defined by the British equestrian trade association (BETA).~~]

(a) The helmet worn must comply with one of the following minimum safety standards or later revisions:

(i) American society for testing materials (ASTM 1163); or,

(ii) UK standards (EN-1384 and PAS-015); or,

(iii) Australian/New Zealand standard (AS/NZ 3838).

(b) The safety vest worn by a jockey shall weigh no more than two pounds and must comply with one of the following minimum standards or later revisions:

(i) British equestrian trade association (BETA):2000 level 1; or,

(ii) euro norm (EN) 13158:2000 1; or,

(iii) American society for testing and materials (ASTM) F2681-08 or F1937; or,

(iv) shoe and allied trade research association (SATRA) jockey vests document M6 Issue 3; or,

(v) Australian racing board (ARB) standard 1.1998.

(c) A safety helmet or safety vest shall not be altered in any manner nor shall the product marking be removed or defaced.

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[15.2.5.13 NMAC - Rp, 15 NMAC 2.5.13, 03/15/01; A, 08/30/07; A, 12/01/08; A, 06/30/09; A, 09/15/09; A, 08/16/10; A, 09/01/10; A, 10/15/14]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

COUNSELING AND THERAPY PRACTICE BOARD

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 27 COUNSELORS AND THERAPISTS
PART 24 LICENSURE FOR MILITARY SERVICE MEMBERS, SPOUSES AND VETERANS

16.27.24.1 ISSUING AGENCY: Regulation and Licensing Department - Counseling and Therapy Practice Board.
[16.27.24.1 NMAC - N, 10-15-14]

16.27.24.2 SCOPE: This part sets forth application procedures to expedite licensure for military service members, spouses and veterans.
[16.27.24.2 NMAC - N, 10-15-14]

16.27.24.3 STATUTORY AUTHORITY: Part 23 of Chapter 16 is promulgated pursuant to and in accordance with the Counseling and Therapy Practice Act, Sections 61-9A-1 to 30 NMSA 1978 (specific authority to promulgate rules is 61-9A-9 and Section 61-1- 34 NMSA 1978.
[16.27.24.3 NMAC - N, 10-15-14]

16.27.24.4 DURATION: Permanent.
[16.27.24.4 NMAC - N, 10-15-14]

16.27.24.5 EFFECTIVE DATE: October 15, 2014, unless a later date is cited at the end of a section.
[16.27.24.5 NMAC - N, 10-15-14]

16.27.24.6 OBJECTIVE: The purpose of this part is to expedite licensure for military service members, their spouses and veterans pursuant to Subsection 34, of Section 1 of Chapter 61 NMSA 1978.
[16.27.24.6 NMAC - N, 10-15-14]

16.27.24.7 DEFINITIONS:

A. "Military service member" means a person who is serving in the armed forces of the United States or in an active reserve component of the armed forces of the United States, including the national guard.

B. "Recent veteran" means a person who has received an honorable discharge or separation from military service within the two years immediately preceding the date the person applied for an occupational or professional license pursuant to this section.
[16.27.24.7 NMAC - N, 10-15-14]

16.27.24.8 APPLICATION REQUIREMENTS:

A. Applications for registration shall be completed on a form provided by the board.

B. The applicant shall provide:

(1) a completed application and corresponding fee pursuant to 16.27.17.9 NMAC;

(2) satisfactory evidence that the applicant is currently licensed in another jurisdiction, including a branch of the United States armed forces, and holds a current license in good standing; the applicant further must provide satisfactory evidence that the applicant has met the minimal licensing requirements in that jurisdiction and that they are substantially equivalent to the licensing requirements for New Mexico licensees in counseling and therapy practice; and

(3) proof of honorable discharge (DD214) or military ID card or accepted proof of military spouse status.

C. Electronic signatures will be acceptable for applications submitted pursuant to Section 14-16-1 through Section 14-16-19 NMSA 1978.
[16.27.24.8 NMAC - N, 10-15-14]

16.27.24.9 RENEWAL REQUIREMENTS:

A. A license issued pursuant to this section shall not be renewed unless the license holder satisfies the requirements for the issuance of a license set forth in 16.27.4 through 16.27.13 and 16.27.22 NMAC and for the renewal of a license set forth in 16.27.3 and 16.27.16 NMAC.

B. A license issued pursuant to this section shall be valid for two years or until the next renewal cycle.

C. The board office mails license renewal notifications to licensees before the license expiration date. Failure to receive the renewal notification shall not relieve the licensee of the responsibility of renewing the license by the expiration date.

D. The renewal application will be available online at the board's website and in paper copy if requested from the board office and must be received at the board office on or before September 30.

E. To renew a license, the licensee must submit the following documentation on or before September 30: a completed license renewal application, verification of continuing education, and the applicable renewal fee at the time of renewal.
[16.27.24.9 NMAC - N, 10-15-14]

History of 16.27.24 NMAC: [RESERVED]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

BOARD OF PHARMACY

This is an amendment to 16.19.4 NMAC, Section 11, effective 10-24-2014.

16.19.4.11 CONSULTANT PHARMACIST:

A. DUTIES AND RESPONSIBILITIES:

(1) To abide by the code of ethics of the American Society of Consultant Pharmacists. Must be qualified to practice as a consultant pharmacist and is to be aware of all federal and state drug laws, rules and regulations related to pharmacy services, and to provide the facility with current information pertaining to drug service.

(2) Ensure that drugs are handled in the facility in which he/she is the consultant pharmacist, in a manner that protect the safety and welfare of the patient.

(3) Set the policy and procedures in the facility as related to all facits of drug handling and distribution; these policies and procedures to be reviewed and updated on an annual basis.

(4) To visit the facility, commensurate with his duties, as specified by Board regulations relative to the facility or by written contract with the administration of the facility not inconsistent with Board regulations.

(5) His/her primary goal and objective shall be the health and safety of the patient, and he/she shall make every effort to assure the maximum level of safety and efficacy in the provision of pharmaceutical services.

(6) The consultant pharmacist shall not condone or participate in any transaction with any practitioner of another health profession, or any other persons whosoever under which fees are divided, or rebates or kickbacks paid or caused to be paid, or which may result in financial exploitation of patients or their families in connection with the provision of drugs and medication or supplies or pharmaceutical services.

B. CONSULTANT PHARMACIST SERVING SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES - UPPER LEVEL CARE - LONG TERM CARE FACILITIES BY ANY OTHER TITLE:

(1) The consultant pharmacist's agreement with the facility shall include but is not limited to the following duties and responsibilities.

(a) Serve as a member of appropriate committees, and attend these meetings.

(b) Development of the Drug Control Procedures Manual.

(c) Monitor on a routine basis all aspects of the total drug distribution system - to be accomplished in a manner designed to monitor and safeguard all areas of the drug distribution system.

(d) Maintain active pharmacist status registration in the state.

(e) Assume responsibility for the destruction or removal of unwanted dangerous drugs and any controlled substances as prescribed by law and regulations.

(f) Maintain a log of all visits and activities in the facility indicating dates and other pertinent data; such logs are to be available to inspection by state drug inspectors upon request.

(g) Furnish and replenish emergency drug supply in acceptable containers. Maintain a log of use and replacement of drugs in the emergency tray.

(h) Make routine inspections of drug storage areas, patient health records, and review drug regimen of each patient at least once a month. Report irregularities, contraindication, drug interactions, etc., to the medical staff.

(i) Provide or make arrangements for provision of pharmacy services to the facility on a 24-hour 7 days a week basis, including stat orders.

(j) Provide in-service training of staff personnel as outlined in the procedures manual.

(k) Meet all other responsibilities of a consultant pharmacist as set forth in the Board regulations and federal or state laws and which are consistent with quality patient care.

(l) The contract consultant pharmacist to a SNF or ICF facility, that is required to review patients' drug regimen as set forth in Subparagraph h of Paragraph 1 of Subsection B of 16.19.4.11 NMAC, who is under contract as sole supplier of unit-doses/state of the art medications, shall be exempt from charges of Unprofessional Conduct under Paragraph 10 of Subsection B of 16.19.4.9 NMAC.

(m) The consultant pharmacist to a SNF or ICF facility who delivers drugs in a unit-dose system, approved by an agent of the Board, which is a tightly sealed, unopened, individual dose, shall be exempt from the requirements of 16.19.6.14 NMAC, Prohibition of Resale of Drugs. The regulation shall not prohibit the return to the pharmacy stock, where partial credit may be given in accordance with any federal or state law or regulation, to the patient for such medication, when the physician discontinues the drug therapy, the patient expires or for any other reason, other than an outdated drug.

(n) Customized Patient Medication Packages; In lieu of dispensing one, two, or more prescribed drug products in separate containers or standard vial containers, a pharmacist may, with the consent of the patient, the patient's care-giver, the prescriber, or the institution caring for the patient, provide a customized patient medication package. The pharmacist preparing a patient medication package must abide by the guidelines as set forth in the current edition of the U.S. Pharmacopoeia for labeling, packaging and record keeping.

(o) Repackaging of Patient Medication Packages; In the event a drug is added to or discontinued from a patient's drug regimen, when a container within the patient medication package has more than one drug within it, the pharmacist may repackage the patient's patient medication package and either add to or remove from the patient medication packaged as ordered by the physician. The same drugs returned by the patient for repackaging must be reused by the pharmacist in the design of the new patient medication package for the new regimen, and any drug removed must either be destroyed, returned to the DEA or returned to the patient properly labeled. Under no circumstances may a drug within a container of a patient medication package which contains more than one drug be returned to the pharmacy stock.

(p) Return of Patient Medication Package Drugs.

(i) Patient medication package's with more than one drug within a container: Patient medication packages with more than one drug within a container may not under any circumstances be returned to a pharmacy stock.

(ii) Patient Medication Package's with only one drug within a container: 1 Non-Institutional: A patient medication package stored in a non-institutional setting where there is no assurance of storage standards may not be returned to pharmacy stock. 2 Institutional: A patient medication package stored in an institutional setting where the storage and handling of the drugs are assured and are consistent with the compendia standards may be returned to the pharmacy stock provided the following guidelines are followed: (1) the drug is to be kept within the patient medication package and it is to remain sealed and labeled until dispensed; (2) the expiration date of drug shall become 50% of the time left of the expiration for the drug; (3) no Schedule II drugs may be returned to inventory; and (4) proper record keeping for the addition of other scheduled drugs into inventory must be done.

(2) When a consultant pharmacist enters into a written contractual agreement with a facility to which he/she will provide service.

(a) The consultant pharmacist whose practice is not in the immediate vicinity of the facility for which he has entered into a written service agreement, shall have a written agreement with a local pharmacist to be available on any emergency basis. The consultant pharmacist shall be responsible for the

proper training and instruction of such local pharmacist. Said local pharmacist shall be known as a "co-consultant". The vendor shall be responsible for the safety and efficacy of back-up pharmaceutical services he provides.

(b) A copy of these agreements must be filed with the Board of Pharmacy and the facility. Any termination of such agreement shall be reported in writing, within ten (10) days, of termination to the Board and to the administrator.

(c) Should a local pharmacist (co-consultant) not be available, the consultant pharmacist must provide an alternative procedure approved by the Board. If the consultant is also the vendor, then such alternative procedure must reasonably assure rapid delivery of drugs; medical supplies and pharmacy service to the facility.

C. CONSULTANT PHARMACIST - CLINIC FACILITY:

(1) The consultant pharmacist providing services to a clinic shall.

(a) Assume overall responsibility for clinic pharmacy services, for clinic pharmacy supportive personnel, and for procedures as outlined in the procedures manual, including all records of drugs procured, administered, transferred, distributed, repackaged or dispensed from the clinic.

(b) Assume responsibility for the destruction or removal of unwanted or outdated dangerous drugs, including controlled substances, as required by laws and regulations.

(c) Develop the pharmacy services procedures manual for the clinic establishing the system for control and accountability of pharmaceuticals.

(d) Provide in-service education and training to clinic staff, as applicable.

(e) Report in writing to the Board within ten (10) days, any termination of services to the clinic. Report in writing to the Board the names and places of employment of any pharmacy technicians under the supervision of the consultant pharmacist.

(f) Comply with all other provisions of Part 10, Limited Drug Clinics, as applicable to the individual clinic facility.

(g) The consultant pharmacist shall personally visit the clinic on the minimum basis described in subparagraphs (a) through (c) [(i) through [~~(iii)~~] (iv)] to ensure that the clinic is following set policies and procedures. Visitation schedules are as follows.

(i) Class A clinics shall have the on-site services of a consultant pharmacist for the dispensing or distribution of dangerous drugs. The consultant pharmacist shall comply with Paragraphs 4, 5 and 7 of Subsection A of [~~16.19.4.17 NMAC~~] 16.19.4.16 NMAC of this regulation.

(ii) Class B clinics shall have the services of a consultant pharmacist as listed below: 1. Category 1 clinics shall be visited by the consultant pharmacist at least bi-monthly. 2. Category 2 clinics shall be visited by the consultant pharmacist at least monthly. 3. Category 3 clinics shall be visited by the consultant pharmacist at least bi-weekly.

(iii) Class C clinics shall be visited by the consultant pharmacist at least every three months.

(iv) Class D clinic shall be reviewed at least once yearly during school session.

(h) The consultant pharmacist shall review the medical records of not less than 5% of a Class B clinics patients who have received dangerous drugs (as determined by the dispensing or distribution records) since the consultant pharmacist's last visit. Such review shall be for the purpose of promoting therapeutic appropriateness, eliminating unnecessary drugs, and establishing the medical necessity of drug therapy, by identifying over-utilization or under-utilization, therapeutic duplication, drug-disease contraindications, drug-drug contraindications, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, appropriate medication indication, and/or clinical abuse/misuse. Upon recognizing any of the above, the consultant pharmacist shall take appropriate steps to avoid or resolve the problem which shall, if necessary, include consultation with the prescriber.

(i) The consultant pharmacist shall maintain a log or record of all visits and activities in the clinic. Such record shall include a log of all medical records reviewed, along with a record of all consultant pharmacist interventions and/or consultations. This log or record shall be available for inspection by state drug inspectors upon request.

(j) The consultant pharmacist shall review Class D clinics annually to ensure the clinic is in compliance with training and protocols required by the department of health (DOH).

(i) clinic staff designated by the department of health shall complete a board of pharmacy self-inspection form;

(ii) self-inspection form shall be approved by the consultant pharmacist; and

(iii) clinic staff shall submit the self-inspection form to the board upon initial licensure and at each renewal.

(2) A clinic may petition the Board for an alternative visitation schedule as set forth in R of 16.19.10.11 NMAC.

D. CONSULTANT PHARMACISTS SERVING CUSTODIAL CARE FACILITIES:

(1) Custodial Care Facility as used in this regulation includes: Any Facility which provides care and services on a continuing basis, for two or more in-house residents, not related to the operator, and which maintains custody of the residents' drugs.

(2) Any facility which meets the requirements outlined in Paragraph 1 of Subsection D of 16.19.4.11 NMAC of this section shall be licensed by the Board of Pharmacy, engage a consultant pharmacist, whose duties and responsibilities are indicated in Paragraph 3 of Subsection D of 16.19.8.11.A NMAC.

(3) Procurement of drugs or medications for residents will be on the prescription order of a licensed physician - written or by oral communication, which order shall be reduced to writing by the pharmacist as required by law. Refills shall be as authorized by the physician. When refill authorization is indicated on the original prescription, a refill for a resident may be requested by the administrator of the licensed facility or his designee by telephone to the consultant pharmacist, or the providing pharmacy.

(4) The administrator or a designated employee of the facility will sign a receipt for prescription drugs upon delivery.

(5) All prescription drugs will be stored in a locked cabinet or room and the key will be assigned to a designated employee or the administrator as indicated in the procedures manual.

(6) Proper storage as stipulated in the official compendium USP/NF will be the responsibility of the licensed facility.

(7) Records - the consultant pharmacist shall be responsible for the following records:

(a) incoming medications - including refills;

(b) record of administration;

(c) waste or loss; This accountability record shall be maintained on a patient log, on forms provided to the consultant pharmacist

by the Board of Pharmacy.

(8) All prescription containers shall be properly labeled as required in 16.19.11 NMAC. No bulk containers of legend drugs will be kept on the premises.

(9) Consultant pharmacist shall include in the procedures manual the name of individual(s) responsible for the assistance with the medication.

(10) It shall be the responsibility of the pharmacist to give proper training/instruction to the person(s) at the facility who have day-to-day responsibility for receipt and administration of medications to resident when adverse reactions, special diet, or any other information relative to the administration of a drug is needed by the staff.

(11) The consultant pharmacist shall be required to maintain a patient profile on each individual, if applicable to the facility and individual.

(12) The consultant pharmacist shall visit the facility no less than once a quarter or more often, commensurate with patient drug regimen and shall be available in emergencies, when needed. A log shall be maintained indicating all visits to the facility and noting any activities or irregularities to be recorded or reported. This log shall be available for state drug inspectors' review upon request.

(13) The consultant shall be responsible for the preparation of a procedures manual outlining procedures for the receipt, storage, record keeping, maintenance of patient profiles, administration and accountability of all legend drugs and procedures for the removal and destruction of unwanted, unused, outdated or recalled drugs - controlled substances shall be handled pursuant to state and federal regulations.

E. No drug that has been dispensed pursuant to a prescription and has left the physical premises of the facility licensed by the board shall be dispensed or reused again except the re-labeling and reuse of pharmaceuticals may be permitted in the following situations: in a correctional facility, licensed by the board, under the following circumstances dangerous drugs, excluding controlled substances, may be re-used:

(1) the patients must reside in the same facility;

(2) the reused medication must have been discontinued from the original patient's drug regimen;

(3) the drug was never out of the possession of the licensee "keep on person pharmaceuticals may never be reused";

(4) the drugs were originally dispensed in packaging that is unopened, single-dose or tamper-evident containers;

(5) the patient receiving the re-labeled medication must have a valid prescription/order for the medication that is to be reused;

(6) repackaging and re-labeling may only be completed on site by the consultant pharmacist designated for that facility.

F. The consultant pharmacist must maintain records at the facility for three years containing the following information:

(1) date when the re-labeling occurred;

(2) the name and ID of the patient for whom the medication was originally intended for and the date in which it was discontinued from his or her drug regimen;

(3) the name and ID of the patient who will receive the reused medication;

(4) the name, strength and amount of the medication being reused;

(5) the name of pharmacist re-labeling the medication;

(6) pursuant to 16.19.10.11 NMAC the pharmacist must label the reused pharmaceutical and maintain a dispensing log for all such re-issued pharmaceuticals and the expiration date for such re-issued drugs shall be no greater than 50 percent of the time remaining from the date of repackaging until the expiration date indicated on the original dispensing label or container.

[08-27-90; 16.19.4.11 NMAC - Rn, 16 NMAC 19.4.11, 03-30-02; A, 06-30-06; A, 10-24-14]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

BOARD OF PHARMACY

This is an amendment to 16.19.10 NMAC, Section 11, effective 10-24-2014.

16.19.10.11 PUBLIC HEALTH CLINICS:

A. CLINIC LICENSURE:

(1) All clinics where dangerous drugs are administered, distributed or dispensed shall obtain a limited drug permit as described in Section 61-11-14 B (6) of the Pharmacy Act which consists of the following types:

(a) Class A clinic drug permit for clinics where:

(i) dangerous drugs are administered to patients of the clinic;

(ii) more than 12,500 dispensing units of dangerous drugs are dispensed or distributed annually;

(iii) clinics dispensing only one class of dangerous drug or controlled substance, such as oral contraceptives or methadone, may be approved by the board as a Class B3 clinic;

(b) Class B clinic drug permit for clinics where dangerous drugs are:

(i) administered to patients of the clinic; and

(ii) dispensed or distributed to patients of the clinic. Class B drug permits shall be issued by categories based on the number of dispensing units of dangerous drugs to be dispensed or distributed annually, as follows: 1. CATEGORY 1 up to 2,500 dispensing units; 2. CATEGORY 2 from 2,501 - 7,500 dispensing units; 3. CATEGORY 3 from 7,501 - 12,500 dispensing units;

(c) Class C clinic drug permit for clinics where dangerous drugs are administered to patients of the clinic.

(d) Class D clinic drug permit for school health offices (which does not include a Class A, B, or C school based health clinic) where emergency dangerous drugs are maintained for administration to students of the school.

B. FORMULARIES:

(1) For all clinic types, drug procurement and storage is limited to the drugs listed in the dispensing formulary for the clinic. The formulary shall be developed by the pharmacy and therapeutics committee of the facility, or if no such committee exists, by the pharmacist and medical director of the clinic. The formulary drugs shall be appropriate for the scope of medical services provided at the clinic facility. A dangerous drug with the same generic name is considered one drug within the formulary (ie) all dosage forms and packages of ampicillin are considered one drug.

(2) For all clinic types, drug procurement and storage is limited to the drugs listed in the administration formulary for on-site administration. The formulary shall be developed by the pharmacy and therapeutics committee of the facility, or if no such committee exists, by the pharmacist and medical director of the clinic. The formulary drugs shall be appropriate for the scope of medical services provided at the clinic facility. A dangerous drug with the same generic name is considered one drug within the formulary (ie) all dosage forms and packages of ampicillin are considered

one drug.

(3) [~~A clinic may petition the board for an alternative dispensing formulary as set forth in Subsection R of 16.19.10.11 NMAC.~~] For Class D clinic drug permits the approved drugs are albuterol inhaler and epinephrine auto-injector.

(4) A clinic may petition the board for an alternative dispensing formulary as set forth in Subsection R of 16.19.10.11 NMAC.

C. CONSULTANT PHARMACIST:

(1) Any facility licensed as a clinic by the board which does not employ a staff pharmacist must engage the services of a consultant pharmacist, whose duties and responsibilities are described in Subsection C of 16.19.4.11 NMAC.

(2) The consultant pharmacist shall wear an identification badge listing his name and job title while on duty in the clinic.

D. PHARMACY TECHNICIANS AND SUPPORT PERSONNEL:

(1) Pharmacy technicians, working in a clinic under the supervision of the pharmacist, may perform activities associated with the preparation and distribution of medications, including prepackaging medications and the filling of a prescription or medication order. These activities may include counting, pouring, labeling and reconstituting medications.

(2) The pharmacist shall ensure that the pharmacy technician has completed the initial training required in Subsection A of 16.19.22.9 NMAC.

(3) A written record of the initial training and education will be maintained by the clinic pursuant to requirements of Subsection C of 16.19.22.9 NMAC.

(4) The permissible ratio of pharmacy technicians to pharmacists on duty is to be determined by the pharmacist in charge or consultant pharmacist.

(5) Support personnel may perform clerical duties associated with clinic pharmacy operations, including computer data entry, typing of labels, processing of orders for stock, duties associated with maintenance of inventory and dispensing records.

(6) The pharmacist is responsible for the actions of personnel; allowing actions outside the limits of the regulations shall constitute unprofessional conduct on the part of the pharmacist.

(7) Name tags including job title, shall be required of all personnel while on duty in the clinic.

E. PROCUREMENT OR RECEIPT OF DANGEROUS DRUGS:

(1) The system of procurement for all drugs shall be the responsibility of the pharmacist.

(2) Records of receipt of dangerous drugs and inventories of controlled substances shall be maintained as required by the Drug, Device and Cosmetic Act 26-1-16 and the Controlled Substances Act 30-31-16 and board of pharmacy regulation 16.19.20 NMAC.

F. REPACKAGING:

(1) Repackaging from bulk containers to dispensing units for distribution at locations other than the site of repackaging requires FDA registration, whether or not the repackaged drugs enter interstate commerce. (See FDA Regulations Title 21, Sections 207, 210 and 211).

(2) Repackaging of drug from bulk containers into multiple dispensing units for future distribution to clinic patients at the site of repackaging may be done by a physician, dentist, pharmacist, or by a pharmacy technician under the supervision of the pharmacist as defined in Subsection B of 16.19.22.7 NMAC. All drugs repackaged into multiple dispensing units by a pharmacy technician must undergo a final check by the pharmacist.

(3) A record of drugs repackaged must be maintained, to include the following.

(a) Date of repackaging.

(b) Name and strength of drug.

(c) Lot number or control number.

(d) Name of drug manufacturer.

(e) Expiration date (per USP requirements).

(f) Total number of dosage units (tabs, caps) repackaged (for each drug).

(g) Quantity per each repackaged unit container.

(h) Number of dosage units (tabs, caps) wasted.

(i) Initials of repackager.

(j) Initials of person performing final check.

(4) All dispensing units of repackaged medication must be labeled with the following information.

(a) Name, strength, and quantity of the drug.

(b) Lot number or control number.

(c) Name of manufacturer.

(d) Expiration date.

(e) Date drug was repackaged.

(f) Name or initials of repackager.

(g) Federal caution label, if applicable.

(5) Repackaged units must be stored with the manufacturer's package insert until relabeled for dispensing. as specified under Subsection G of 16.19.10.11 NMAC.

G. CLINIC DISPENSING OR DISTRIBUTING:

(1) Drugs shall be dispensed or distributed only to clinic patients on the order of a licensed practitioner of the clinic.

(2) The clinic practitioner shall record the prescribed drug therapy on the patient medical record indicating the name, strength, quantity and directions for use of the prescribed drug. This information shall be initialed or signed by the practitioner. A separate prescription form in addition to the medical record may be used.

(3) The prescription order may then be prepared by the practitioner, pharmacist or technician under the supervision of the pharmacist and a dispensing label affixed to the dispensing unit of each drug. The following information shall appear on the label affixed to the dispensing unit.

(a) Name of patient.

(b) Name of prescriber.

(c) Date of dispensing.

(d) Directions for use.

(e) Name, strength, and quantity of the drug.

(f) Expiration date.

(g) Name, address and phone number of the clinic.

(h) Prescription number, if applicable.

(4) The pharmacist or practitioner must then provide a final check of the dispensing unit and sign or initial the prescription or dispensing record.

(5) Refill prescription orders must also be entered on the patient's medical record and the dispensing record.

H. PATIENT COUNSELING:

(1) Each clinic licensed by the board shall develop and provide to the board policies and procedures addressing patient counseling which are at least equivalent to the requirements of

Subsection F of 16.19.4.16 NMAC.

(2) If the consultant pharmacist is absent at the time of dispensing or distribution of a prescription from clinic drug stock to a clinic patient, the patient shall be provided written information when appropriate on side effects, interactions, and precautions concerning the drug or device provided. The clinic shall make the consultant pharmacist's phone number available to patients for consultation on drugs provided by the clinic.

I. DISPENSING RECORDS: A record shall be kept of the dangerous drugs dispensed indicating the date the drug was dispensed, name and address of the patient, the name of the prescriber, and the quantity and strength of the drug dispensed. The individual recording the information and the pharmacist or clinic practitioner who is responsible for dispensing the medication shall initial the record.

J. SAMPLE DRUGS: Samples of medications which are legend drugs or which have been restricted to the sale on prescription by the New Mexico board of pharmacy are subject to all the record keeping, storage and labeling requirements for prescription drugs as defined by NMSA 26-1-16 and other applicable state and federal laws.

K. DRUG STORAGE:

(1) Space for the storage and dispensing of drugs shall have proper ventilation, lighting, temperature controls, refrigeration and adequate security as defined by the board or its' agent. Minimum space requirements for main drug storage areas are as follows:

(a) for Class A clinics - 240 square foot room;

(b) for Class B clinics;

(i) categories 1, and 2 - 48 square foot room; and

(ii) category 3 - 96 square foot room;

(c) for Class C clinics - an area adequate for the formulary.

(2) Controlled substances must be stored as defined in 16.19.20.48 NMAC.

(3) All drug containers in the facility shall be clearly and legibly labeled as required under Subsection F of 16.19.10.11 NMAC – (REPACKAGING and Sections 26-1-10 and 26-1-11 of the Drug, Device and Cosmetic Act).

(4) Purchase, storage and control of drugs shall be designed to prevent having outdated, deteriorated, impure or improperly standardized drugs in the facility.

(5) Access to the drug storage area shall be limited to clinic practitioners, the pharmacist, and supportive personnel who are performing pharmacy-related functions.

(6) Clinics licensed by the board prior to adoption of this regulation are exempt from the minimum space requirements set forth in Paragraph (1) of Subsection K of 16.19.10.11 NMAC. When these facilities change ownership, remodel the drug storage area, or relocate after May 15, 1996, the requirements of Paragraph (1) of Subsection K of 16.19.10.11 NMAC shall apply.

L. DISPOSITION OF UNWANTED OR OUTDATED DRUGS:

(1) The pharmacist shall be responsible for removal of recalled, outdated, unwanted or otherwise unusable drugs from the clinic inventory.

(2) Options for disposal are destruction under the supervision of the pharmacist or return to the legitimate source of supply.

M. REFERENCE MATERIAL: Adequate reference materials are to be maintained in the clinic. These shall include a current product information reference such as USPDI, facts and comparisons, or American hospital formulary service; a copy of the state drug laws and regulations and a poison treatment chart with the regional poison control center's telephone number.

N. PROCEDURES MANUAL:

(1) Written policies and procedures shall be developed by the pharmacy and therapeutics committee, or if none, by the pharmacist-in-charge and clinic's executive director, and implemented by the pharmacist-in-charge.

(2) The policy and procedure manual shall include but not be limited to the following:

(a) a current list of the names and addresses of the pharmacist-in-charge, consultant-pharmacist, staff pharmacist(s), supportive personnel designated to provide drugs and devices, and the supportive personnel designated to supervise the day-to-day pharmacy related operations of the clinic in the absence of the pharmacist;

(b) functions of the pharmacist-in-charge, consultant pharmacist, staff pharmacist(s) and supportive personnel;

(c) clinic objectives;

(d) formularies;

(e) a copy of the written agreement, if any, between the pharmacist and the clinic;

(f) date of the last review or revision of policy and procedure manual; and

(g) policies and procedures for

(i) security;

(ii) equipment;

(iii) sanitation;

(iv) licensing;

(v) reference materials;

(vi) drug storage;

(vii) packaging and repackaging;

(viii) dispensing and distributing;

(ix) supervision;

(x) labeling and relabeling;

(xi) samples;

(xii) drug destruction and returns;

(xiii) drug and device procuring;

(xiv) receiving of drugs and devices;

(xv) delivery of drugs and devices;

(xvi) record keeping; and

(xvii) scope of practice.

(3) The procedures manual shall be reviewed on at least an annual basis. A copy of the manual shall be kept at the clinic at all times.

(4) A written agreement defining specific procedures for the transfer, storage, dispensing and record keeping of clinic dangerous drug stock from a licensed New Mexico pharmacy will be included in the procedures manual. The agreement will be signed by a clinic official and pharmacy official and reviewed annually.

O. PATIENT RECORD: clinics shall maintain patient records as defined in Subsection C of 16.19.4.16 NMAC.

P. DRUG TRANSFER TO A PHARMACY:

(1) Dangerous drug stock unopened containers, except samples, may be transferred physically or electronically to a pharmacy licensed in New Mexico for dispensing to clinic patients.

(a) record of transfer shall be maintained at the clinic and the pharmacy. It will include:

(i) date of transfer or shipment;

(ii) name and strength of drug;

(iii) package size;

(iv) number of packages;

(v) manufacturer or repackager; and

(vi) lot number and expiration date, unless transferred from a clinic supplier to a pharmacy.

(b) A copy of the transfer or shipment record will be provided to the pharmacy at the time of transfer. This record will be compared with the drugs for accuracy and retained by the pharmacy as the receipt document separate from other receiving records of the pharmacy.

(c) Transferred clinic drugs will be stored in the restricted area of the pharmacy and physically separated from all other pharmacy drugs.

(d) Drugs returned to the clinic by the pharmacy will be documented in a transfer record as described in Subparagraph (a) of Paragraph (1) of Subsection P of 16.19.10.11 NMAC. A copy will be maintained by the pharmacy and the clinic.

(2) A clinic may petition the board for an alternative drug transfer system as set forth in Subsection Q of 16.19.10.11 NMAC.

(3) The formulary of transferred drugs for pharmacy dispensing is restricted to the clinic's scope of practice.

Q. PHARMACY DISPENSING: Clinic drug stock may be transferred to, and maintained by, a pharmacy for dispensing to clinic patients as provided in this regulation. Clinic drug stock may be dispensed by the pharmacy if:

(1) the drugs are dispensed only to a clinic patient with a valid prescription from a practitioner of that clinic;

(2) clinic prescriptions for clinic drugs are maintained separately from other prescriptions of the pharmacy;

(3) the prescription is dispensed in a container with a label attached which reads "DISPENSED FOR (clinic name and address) BY (pharmacy name and address)";

(4) all packaging and labeling requirements for prescriptions dispensed by a pharmacy have been met; and

(5) patient records and counseling requirements have been maintained separately for all clinic patients whose prescriptions were filled by the pharmacy from clinic drug stock.

R. PETITION FOR ALTERNATIVE PLAN:

(1) A clinic may petition the board for an alternative visitation schedule, dispensing formulary, or drug transfer system (each an "alternative plan") as follows.

(a) Prior to implementation of any alternative plan, the clinic shall provide to the board a written petition that describes the proposed alternative plan and justifies the request. The petition shall include an affidavit that states that the clinic has a current policy and procedures manual on file, has adequate security to prevent diversion of dangerous drugs, and is in compliance with all rules applicable to the clinic. The affidavit shall be signed by the medical director, the consultant pharmacist, and the owner or chief executive officer of the clinic. In addition, a petition for an alternative drug transfer system must include a detailed, written description of the proposed alternative transfer system in the policy and procedures manual describing:

(i) drug ownership;

(ii) drug ordering;

(iii) drug shipping;

(iv) drug receiving;

(v) drug accountability system;

(vi) formulary for transfer; and

(vii) records of transfer.

(b) The board may approve or deny the petition for an alternative plan, at the board's discretion. The board may consider the following:

(i) degree of compliance by the clinic on past compliance inspections;

(ii) size and type of the patient population;

(iii) number and types of drugs contained in the clinic's formulary;

(iv) the clinic's objectives; and

(v) impact on the health and welfare of the clinic's patients.

(2) A copy of the board approved alternative plan shall be maintained at the clinic's license location for review by the board or its agent.

(3) The board may terminate the alternative plan if the board determines that the clinic's status or other circumstances justifying the alternative plan have changed.

[05-15-96; 16.19.10.11 NMAC - Rn, 16 NMAC 19.10.11, 03-30-02; A, 08-12-13; A, 10-24-14]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

BOARD OF PHARMACY

This is an amendment to 16.19.11, Section 8, effective 10-24-2014.

16.19.11.8 MINIMUM STANDARDS:

A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:

(1) The pharmaceutical service shall be organized and maintained primarily for the benefit and safety of the patient.

(2) All medications administered to patients shall be by direct order of a physician, or other licensed practitioner, as defined in the Pharmacy Act, 61-11-2P.

(3) The pharmaceutical service shall be under the direction of a registered pharmacist, who may be on a part-time or consultant basis.

(4) Policies relating to the control, distribution and administration of medications shall be developed by the pharmacist. Preparation of a written procedures manual shall be the responsibility of the pharmacist.

(5) An automatic stop-order policy shall be adopted to provide guidance in these instances where medications ordered are not specifically limited as to time or number of doses.

(6) Adequate facilities to be provided for storage of medications. Proper labeling is required on each patient's medication container.

(7) Complete records - In addition to those records specifically required by federal and state laws, records shall be maintained of the receipt, use, or disposition of medications. The receipt and destruction journal shall show:

(a) date;

(b) patient's name;

(c) pharmacy's name;

(d) name of drug;

(e) strength and dosage form;

(f) prescription number;

(g) quantity;

(h) initials of person accepting delivery; and

(i) inventory of drugs to be destroyed.

(8) Appropriate current drug reference sources shall be provided at the facility.

(9) In licensed nursing homes an emergency drug supply shall be maintained to be used in a medical emergency situation, contents and quantity to be determined by a physician, nursing director and the pharmacist of each institution. In licensed custodial care facilities [~~a~~] an emergency drug supply may be used. This emergency drug supply shall be assessed only when licensed personnel are on duty. In licensed custodial care facilities only, the emergency drug tray shall not contain any controlled substances. A list of the contents of the emergency drug supply shall be attached [~~tot~~] to the outside of the tray.

(10) Medication errors and drug reactions should be documented and a method of reporting shall be addressed in the pharmacy procedure manual.

B. POLICY AND PROCEDURES MANUAL:

(1) The pharmacist shall be responsible for the preparation of a written procedures manual, the aim of which shall be:

(a) To improve communications with the facility;

(b) To improve patient care;

(c) To aid in personnel training;

(d) To increase legal protection;

(e) To aid in evaluating performance;

(f) To promote consistency and continuity.

(2) There shall be a copy of the policy and procedure manual at each facility location. This copy must be read and initialed by all personnel responsible for the procurement, administration or control of the patient's medication.

(3) The consultant pharmacist shall make an annual review of the procedures manual. Findings of which shall be reported to the facility administration.

(4) Guidelines for developing a pharmaceutical procedures manual;

(a) Drug Policy: A written policy concerning methods and procedures for the pharmaceutical services stating the appropriate methods and procedures for obtaining, dispensing and administering drugs and biologicals.

(b) Prescription Drug Orders: The designated agent of the facility may transcribe prescription drug orders from a licensed practitioner and transmit those orders via telephone or facsimile to the pharmacy.

(c) Licensed practitioners will identify the designated agents of a facility by written authorization according to the facility's policy and procedures manual.

(d) The facility shall have a medication administration record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include:

(i) Name of resident;

(ii) Date given;

(iii) Drug product name;

(iv) Dosage and form;

(v) Strength of drug;

(vi) Route of administration;

(vii) How often medication is to be taken;

(viii) Time taken and staff initials;

(ix) Dates when the medication is discontinued or changed;

(x) The name and initials of all staff administering medications.

(e) Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting.

(f) All PRN medications shall have complete detail instructions regarding the administering of the medication. This shall include:

(i) Symptoms that indicate the use of the medication;

(ii) Exact dosage to be used;

(iii) The exact amount to be used in a 24 hour period.

(g) Describe medication storage, procedures, and function at the nursing stations.

(h) Describe the medication administration system used with means of verifying accuracy of delivered dosage. Describe the procedure for recording missed or refused doses and the procedure followed for missed or refused doses.

(i) State that medications prescribed for one patient shall not be administered to any other patient.

(j) Describe policy concerning self-administration of medications by patients. A physician's order shall be required before any resident is allowed to self-administer medications.

(k) State procedures for documenting medication errors and drug reactions:

(i) Should a staff member of the facility notice an error, possible overdose, or any discrepancy in any of the prescriptions filled by the pharmacy, they will immediately contact the pharmacy. If necessary, the pharmacy will contact the physician.

(ii) In the event of [~~a~~] an adverse drug reaction the facility will immediately contact the physician.

(l) List labeling and storage requirements of medications in conformity with the official compendium (USP/NF).

(5) OTHER INFORMATION

(a) Emergency Drug Tray - use, inventory control, replacement of drugs, security when licensed staff is not on duty.

(b) Location of Emergency Drug Tray.

(c) 24-hour emergency pharmaceutical services.

(d) Part-time or consultant pharmacist hours on premises.

(e) In-service training.

(f) Drug information service.

(g) Automatic stop orders.

(h) Controlled substances - inventory, security and control.

(i) Renewal of physician's orders.

(j) A policy concerning "PASS" medications.

(k) Discontinued medication.

(l) Records and standards of storage of over-the-counter drugs.

(m) Drug receipt and disposition records.

(6) DRUG DISTRIBUTION

(a) All dangerous drugs [~~will~~] shall be obtained

from a properly licensed facility. Stock dangerous drugs acquired, maintained and administered by or at the nursing home shall be listed in the nursing home policy and procedure manual [~~and approved by the Board of Pharmacy~~]. The stock dangerous drugs shall be used when a licensed nurse (LPN or RN) is on duty. The following is the approved list of stock dangerous drugs:

(i)
Sterile normal saline and water - injectable;

(ii)
Sterile normal saline and water - irrigation;

(iii)
Tuberculin testing solution;

(iv)
[~~Hepatitis B vaccine;~~] Vaccines as recommended by the centers for disease control (CDC) and prevention's advisory committee on immunization practices and appropriate for the facility population served;

(v)
[~~Flu vaccine.;~~] Any additional nursing home stock dangerous drugs must be defined and listed in the policy and procedure manual and must be approved by the board of pharmacy or board's agent prior to obtaining or using.

(b) No drugs will be compounded by other than a pharmacist unless done in accordance with that exemption in the State Pharmacy Act - Section 61-11-22.

(c)
The pharmacist shall be responsible for the proper removal and destruction of unused, discontinued, outdated or recalled drugs.

(d)
The pharmacist shall require the person receiving a patient's drugs from the pharmacist or his agent to sign a drug receipt record listing those prescriptions received from the pharmacy.

(e)
The pharmacist shall provide the staff with a receipt listing those prescriptions removed from the facility.

(f)
Medications will be released to patients on discharge from the facility only upon the authorization of the physician.

(7) DRUG CONTROL

(a) All state and federal laws relating to storage, administration and disposal of controlled substances and dangerous drugs shall be complied with.

(b)
Separate sheets shall be maintained for controlled substances records indicating the following information for each type and strength of controlled substances: date, time administered, name of patient, dose, physician's name, signature of person administering dose, and balance of controlled substance in the container.

(c)
All drugs shall be stored in locked cabinets, locked drug rooms, or state of the art locked medication carts.

(d)
Medication requiring refrigeration shall be kept in a secure locked area of the refrigerator or in the locked drug room.

(e)
All refrigerated medications will be kept in separate refrigerator or compartment from food items.

(f)
Medications for each patient shall be kept and stored in their originally received containers, and stored in separate compartments. Transfer between containers is forbidden, waiver shall be allowed for oversize containers and controlled substances at the discretion of the drug inspector.

(g)
Prescription medications for external use shall be kept in a locked cabinet separate from other medications.

(h)
No drug samples shall be stocked in the licensed facility.

(i)
All drugs shall be properly labeled with the following information:

(i)
Patient's full name;

(ii)
Physician's name;

(iii)
Name, address and phone number of pharmacy;

(iv)
Prescription number;

(v)
Name of the drug and quantity;

(vi)
Strength of drug and quantity;

(vii)
Directions for use, route of administration;

(viii)
Date of prescription (date of refill in case of a prescription renewal);

(ix)
Expiration date where applicable: The dispenser shall place on the label a suitable beyond-use date to limit the patient's use of the medication. Such beyond-use date shall be not later than (a) the expiration date on the manufacturer's container, or (b) one year from the date the drug is dispensed, whichever is earlier;

(x)
Auxiliary labels where applicable;

(xi)
The Manufacturer's name;

(xii)
State of the art drug delivery systems using unit of use packaging require items i and ii above, provided that any additional information is readily available at the nursing station.

(j)
Customized Patient Medication Packages: In lieu of dispensing one, two, or more prescribed drug products in separate containers or standard vial containers, a pharmacist may, with the consent of the patient, the patient's care-giver, the prescriber, or the institution caring for the patient, provide a customized patient medication package. The pharmacist preparing a patient medication package must abide by the guidelines as set forth in the current edition of the U. S. Pharmacopoeia for labeling, packaging and record keeping.

(k)
Repackaging of Patient Medication Packages: In the event a drug is added to or discontinued from a patient's drug regimen, when a container within the patient medication package has more than one drug within it, the pharmacist may repackage the patient's patient medication package and either add to or remove from the patient medication packaged as ordered by the physician. The same drugs returned by the patient for repackaging must be reused by the pharmacist in the design of the new patient medication package for the new regimen, and any drug removed must either be destroyed, returned to the DEA or returned to the patient properly labeled. Under no circumstances may a drug within a container of a patient medication package which contains more than one drug be returned to the pharmacy stock.

(l)
Return of Patient Medication Package Drugs: Patient medication packages with more than one drug within a container may not under any circumstances be returned to a pharmacy stock.

(m)
Patient Medication Packages with only one drug within a container:

(i)
Non-Institutional: A patient medication package stored in a non-institutional setting where there is no assurance of storage standards may not be returned to pharmacy stock;

(ii)
Institutional: A patient medication package stored in an institutional setting where the storage and handling of the drugs are assured and are consistent with the compendia standards may be returned to the pharmacy stock provided the following guidelines are followed: (1) the drug is to be kept within the patient medication package and is to remain sealed and labeled until dispensed; (2) the expiration date of drug shall become 50% of the time left of the expiration for the drug; (3) no Schedule II drugs may be returned to inventory; and (4)

proper record keeping for the addition of other scheduled drugs into inventory must be done.

(8) DRUG INFORMATION

(a) The pharmacist shall be accessible for providing drug information.

(b) A current reference books shall be located in each nursing station.

(c) Each nursing station shall have poison control information and phone number and a conversion chart for pharmaceutical weights and measures, and as a part of the drug procedures manual.

(9) EMERGENCY DRUG SUPPLY

(a) There shall be an accountability record indicating the following:

(i) Name of drug, strength, and amount of medication used;

(ii) Date used;

(iii) Time;

(iv) Patient's name;

(v) Physician's name;

(vi) Nurse administering drug;

(vii) Nature of emergency.

(b) Pharmacist shall make notation of date and time medication replacement is made on the line following that line containing withdrawal information and sign his name, unless the pharmacy chooses to change out the complete emergency box each time it is used. The pharmacy shall keep a record of each time the box is changed and a list of all drugs that were replaced in the box.

(10) Destruction of dispensed drugs for patients in health care facilities or institutions:

(a) The drugs are inventoried and such inventory is verified by the consultant pharmacist. The following information shall be included on this inventory:

(i) name and address of the facility or institution;

(ii) name and pharmacist license number of the consultant pharmacist;

(iii) date of drug destruction;

(iv) date the prescription was dispensed;

(v) unique identification number assigned to the prescription by the pharmacy;

(vi) name of dispensing pharmacy;

(vii) name, strength, and quantity of drug;

(viii) signature of consultant pharmacist destroying drugs;

(ix) signature of witness(es); and

(x) method of destruction.

(b) The drugs are destroyed in a manner to render the drugs unfit for human consumption and disposed of in compliance with all applicable state and federal requirements.

(c) The actual destruction of the drug is witnessed by the consultant pharmacist and one of the following:

(i) An agent of the New Mexico board of pharmacy;

(ii) Facility administrator;

(iii) The director of nursing.

(11) A consultant pharmacist may utilize a waste disposal service or reverse distributor to destroy dangerous drugs and controlled substances in health care facilities, boarding homes or institutions provided the following conditions are met:

(a) The inventory of drugs is verified by the consultant pharmacist. The following information must be included on this inventory:

(i) Name and address of the facility or institution;

(ii) Name and pharmacist license number of the consultant pharmacist;

(iii) Date of packaging and sealing of the container;

(iv) Date the prescription was dispensed;

(v) Unique identification number assigned to the prescription by the pharmacy;

(vi) Name of dispensing pharmacy;

(vii) Name, strength and quantity of drug;

(viii) Signature of consultant pharmacist packaging and sealing container; and

(ix) Signature of the witness.

(b) The consultant pharmacist seals the container or drugs in the presence of the facility administrator, the director of nurses or an agent of the board of pharmacy.

(c) The sealed container is maintained in a secure area at the facility or pharmacy until transferred to the waste disposal service or the reverse distributor by the consultant pharmacist, facility administrator, director of nursing or agent of the board of pharmacy.

(d) A record of the transfer [~~tot he~~] to the waste disposal service or reverse distributor is maintained and attached [~~tot he~~] to the inventory of drugs. Such records shall contain the following information:

(i) Date of the transfer;

(ii) Signature of the person who transferred the drugs to the waste disposal service or reverse distributor;

(iii) Name and address of the waste disposal service or reverse distributor;

(iv) Signature of the employee of the waste disposal service or the reverse distributor who receives the container; and

(v) The waste disposal service or reverse distributor shall provide the facility with proof of destruction of the sealed container.

(12) Record Retention: All records required above shall be maintained by the consultant pharmacist and the health care facility or institution for three years from the date of destruction.

[16.19.11.8 NMAC - Rp 16.19.11.8, 12-15-02; A, 10-24-14]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT

BOARD OF PHARMACY

This is an amendment to 16.19.12 NMAC, Sections 8, 14 and 15, effective 10-24-2014.

16.19.12.8 FEES: All fees shall be paid in advance of the issuance of any license, permit, certificate or replacement of a certificate and shall not be refundable.

[03-07-80...08-27-90; 16.19.12.8 NMAC - Rn, 16 NMAC 19.12.8, 03-30-02; A, 10-24-14]

16.19.12.14 DRUG ROOM PERMIT:

A. Drug Room Permit in Adult Shelter Care or Custodial Care Facility:

(1) 10 or fewer beds:
$100.00 [~~bi-ennialy~~] bi-ennially

(2) 11 or more

beds:
$200.00 [~~bi-ennialy~~] bi-ennially
B. Drug Room Permit in an Intermediate Nursing Home Facility
$200.00 [~~bi-ennialy~~] bi-ennially
C. Drug Room Permit in a Skilled Nursing Home Facility
$200.00 [~~bi-ennialy~~] bi-ennially
D. Duplicate License $10.00
[03-07-80...08-27-90; 16.19.12.14 NMAC - Rn, 16 NMAC 19.12.14, 03-30-02; A, 09-30-03; A, 10-24-14]

16.19.12.15 CLINIC LICENSE FEES: Clinic license fees shall be:
A. Limited Clinic
$300.00 [~~bi-ennialy~~] bi-ennially
B. Intermediate Clinic
$300.00 [~~bi-ennialy~~] bi-ennially
C. Major Clinic
$300.00 [~~bi-ennialy~~] bi-ennially
D. Class D School Clinic
$30.00 bi-ennially
[~~D.~~] E. Duplicate License $10.00
[~~E.~~] F. Animal Control Clinic
$100.00 [~~bi-ennialy~~] bi-ennially
[03-07-80...08-06-94; 12-15-99; 16.19.12.15 NMAC - Rn, 16 NMAC 19.12.15, 03-30-02; A, 09-30-03; A, 10-24-14]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT
BOARD OF PHARMACY

This is an amendment to 16.19.20 NMAC, Section 8, effective 10-24-2014.

16.19.20.8 REGISTRATION REQUIREMENTS: Persons required to register:
A. manufacture - term includes repackagers;
B. distributors - term includes wholesale drug distributors;
C. dispensers - pharmacies, hospital pharmacies, clinics (both health and veterinarian);
D. practitioners - includes a physician, doctor of oriental medicine, dentist, physician assistant, certified nurse practitioner, clinical nurse specialist, certified nurse-midwife, veterinarian, pharmacist, pharmacist clinician, certified registered nurse anesthetists, psychologists, chiropractic examiner, euthanasia technicians or other person licensed or certified to prescribe and administer drugs that are subject to the Controlled Substances Act. Practitioners, excluding veterinarians, must register with the New Mexico prescription monitoring program in conjunction with their controlled substance registration.
E. scientific investigators or researchers;
F. analytical laboratories and chemical analysis laboratories;
G. teaching institutes;
H. special projects and demonstrations which bear directly on misuse or abuse of controlled substances - may include public agencies, institutions of higher education and private organizations;
I. registration waiver: an individual licensed practitioner (e.g., intern, resident, staff physician, mid-level practitioner) who is an agent or employee of a hospital or clinic, licensed by the board, may, when acting in the usual course of employment or business, order controlled substances, for administration to the patients of the facility, under controlled substance registration of the hospital or clinic in which he or she is employed provided that:
(1) the ordering of controlled substances for administration, to the patients of the hospital or clinic, is in the usual course of professional practice and the hospital or clinic authorizes the practitioner to order controlled substances for the administration to its patients under its state controlled substance registration;
(2) the hospital or clinic has verified with the practitioner's licensing board that the practitioner is permitted to order controlled substances within the state;
(3) the practitioner acts only within their scope of employment in that hospital or clinic;
(4) the hospital or clinic maintains a current list of practitioners given such authorization and includes the practitioner's full name, date of birth, professional classification and license number, and home and business addresses and phone numbers;
(5) the list is available at all times to board inspectors, the D.E.A., law enforcement and health professional licensing boards; and
(6) the hospital or clinic shall submit a current list of authorized practitioners with each hospital or clinic controlled substance renewal application.
[16.19.20.8 NMAC - Rp 16 NMAC 19.20.8, 07-15-02; A, 12-15-02; A, 07-15-04; A, 05-14-10; A, 08-31-12; A, 10-24-14]

NEW MEXICO REGULATION AND LICENSING DEPARTMENT
BOARD OF PHARMACY

This is an amendment to 16.19.29 NMAC, Section 7, effective 10-24-2014.

16.19.29.7 DEFINITIONS:
A. "Controlled substance" has the meaning given such term in 30-31-2 NMSA.
B. "Board of pharmacy" means the state agency responsible for the functions listed in 16.19.29.8 NMAC.
C. "Patient" means the [~~person or animal who is the~~] ultimate user of a drug for whom a prescription is issued and for whom a drug is dispensed.
D. "Dispenser" means the person who delivers a Schedule II - V controlled substance as defined in Subsection [~~E~~] F of this section to the ultimate user, but does not include the following:
(1) a licensed hospital pharmacy that distributes such substances for the purpose of inpatient hospital care;
(2) a practitioner, or other authorized person who administers such a substance; or
(3) a wholesale distributor of a Schedule II - V controlled substance;
(4) clinics, urgent care or emergency departments dispensing no more than 12 dosage units to an individual patient within a 72 hour period.
(5) veterinarians or veterinary clinics dispensing to non-human patients.
E. "Prescription monitoring program" (PMP) means a centralized system to collect, monitor, and analyze electronically, for controlled substances, prescribing and dispensing data submitted by pharmacies and dispensing practitioners, of which the data is to be used to support efforts in education, research, enforcement and abuse prevention.
F. "Schedule II, III, IV and V controlled substance" means substances that are listed in schedules II, III, IV, and V of the schedules provided under 30-31-5 to 30-31-10 of NMSA or the federal controlled substances regulation (21 U.S.C. 812).
G. "Report" means a compilation of data concerning a patient, a dispenser, a practitioner, or a controlled substance.
[16.19.29.7 NMAC - N, 07-15-04; A, 06-11-11; A, 08-31-12; A, 10-24-14]

NEW MEXICO DEPARTMENT OF WORKFORCE SOLUTIONS

This is an amendment to 11.3.400 NMAC, Sections 7, 402, 404, 406-410, 415-418, 420-422, and 426 and the creation of a new Section 427, effective 10-15-2014.

11.3.400.7 DEFINITIONS: [~~RESERVED~~]

A. "Account" means the employer account, identified by an account number, established and maintained for each employer, or employer member of a group account, for the purpose of determining liability for payments in lieu of contributions, and from which benefits to eligible claimants can be determined.

B. "Agency" means any officer, board, commission, or other authority charged with the administration of the unemployment compensation law of a participating jurisdiction.

C. "Alternate base period" means the last four completed quarters immediately preceding the first day of the claimant's benefit year.

D. "Annual payroll" means the total taxable amount of remuneration from an employer for employment during a twelve-month period ending on a computation date.

E. "Base period" means the first four of the last five completed quarters as provided in NMSA 1978 Section 51-1-42 A or the alternate base period.

F. "Base-period employers" means the employers of an individual during the individual's base period.

G. "Base-period wages" means the wages of an individual for insured work during the individual's base period on the basis of which the individual's benefit rights were determined.

H. "Benefit payments used to calculate the average benefit cost rate" means all unemployment compensation benefits and state extended benefits paid from the trust fund to claimants with wages from non-reimbursable covered employment.

I. "Common ownership" means that two or more businesses are substantially owned, managed or controlled by the same person or persons.

J. "Computation date" means for each calendar year the close of business on June 30 of the preceding calendar year.

K. "Contributions" means the tax payments required by NMSA 1978 Section 51-1-9 to be made into the fund by an employer on account of having individuals performing services for the employer.

L. "Employing enterprise" means a business activity engaged in by a contributing employing unit in which one or more persons have been employed within the current or the three preceding calendar quarters.

M. "Employment" means services performed by an individual including corporate officers for wages or other remuneration for an employer that has the right, whether utilized or not, to control or direct the individual in the performance of the services at the employer's place of business which includes all locations where services are performed for the employer under the individual's contract of service and the individual is not customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the contract of services.

N. "Experience history" means the benefit charges and payroll experience of the employing enterprise.

O. "Good cause" means unavoidable circumstances which render the employer's records incomplete or inaccessible for the preparation of the report and computation of the contributions due within the time otherwise prescribed and it shall not include any dilatory act or negligence by the employer.

P. "Group account" means the account, identified by an account number, established for two or more employers whose application to become liable for payments in lieu of contributions and for sharing the cost of benefits paid by them, has been approved by the department in accordance with NMSA 1978 Section 51-1-13E.

Q. "Group member" means any employer who has become associated with another or others to form a group account.

R. "Interested agency" means the agency of an interested jurisdiction.

S. "Interested jurisdiction" means any participating jurisdiction to which an election submitted under this rule is sent for its approval.

T. "Jurisdiction" means any state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands or, with respect to the federal government, the coverage of any federal unemployment compensation law.

U. "Knowingly" means having actual knowledge of or acting with deliberate ignorance of or reckless disregard for the prohibition involved.

V. "Participating jurisdiction" means a jurisdiction whose administrative agency has subscribed to the interstate reciprocal coverage arrangement and whose adherence thereto has not terminated.

W. "Predecessor" means the owner and operator of an employing enterprise immediately prior to the transfer of such enterprise.

X. "Services customarily performed by an individual in more than one jurisdiction" means services performed in more than one jurisdiction during a reasonable period, if the nature of the services gives reasonable assurance that they will continue to be performed in more than one jurisdiction or if such services are required or expected to be performed in more than one jurisdiction under the election.

Y. "Successor" means any person or entity that acquires an employing enterprise and continues to operate such business entity.

Z. "Taxable year" means the calendar year beginning the first day of January and ending the thirty-first day of December.

AA. "Total wages for the purpose of computing the reserve ratio and the benefit cost rate" means all wages paid to covered employees for payroll periods ending in a calendar year as reported on the quarterly census of employment and wages.

BB. "Trust fund balance" means the trust fund balance on deposit with the U.S. treasury in the state's account as of June 30 that includes only funds that will be used for payments of benefits to claimants.

CC. "Violates or attempts to violate" means intent to evade, a misrepresentation or a willful nondisclosure.

DD. "Wages" means all remuneration for services, including commissions, bonuses or unpaid loans to employees and the cash value of all remuneration in any medium other than cash.

[11.3.400.7 NMAC - N, 9-1-2001; A, 01-01-2003; A, 10-15-2014]

11.3.400.402 IDENTIFICATION OF EMPLOYEES: Each employer shall report an employee's social security account number in making any report required by the department with respect to such employee. If the employee has no such number, the employer shall request the employee show the employer a receipt issued by the social security administration acknowledging that the employee has filed an application for an account number. The receipt shall be retained by the employee and a copy of the receipt shall be retained by the employer. In making any report required by the department with respect to such an employee, the employer shall

report the date of issue of the receipt, its termination date, the address of the issuing office, and the name and address of the employee exactly as shown in the receipt. [7-15-98; 11.3.400.402 NMAC - Rn & A, 11 NMAC 3.400.402, 9-1-2001; A, 11-15-2012; A, 10-15-2014]

11.3.400.404 WAGE AND CONTRIBUTION REPORTS BY EMPLOYING UNITS:

A. [~~WAGE AND CONTRIBUTION REPORT FILING REQUIREMENTS~~] QUARTERLY EMPLOYMENT & WAGE DETAIL REPORT: An employer's wage and contribution report must be filed [~~on a form prescribed by the department or a reasonable facsimile of the prescribed form~~] electronically on the department's web page on or before the last day of the month immediately following the end of the calendar quarter. If the due date falls on a Saturday, Sunday or legal holiday, the report is due on the next department business day. A wage and contribution report must be filed even though no wages were paid or no contribution or tax is due for the quarter unless the employer's liability has been terminated or suspended pursuant to NMSA 1978 Section 51-1-18. Each wage and contribution report must include only wages, as the term is defined in NMSA 1978 Section 51-1-42(T), paid during the quarter being reported. Corrections of errors made on previously submitted reports must be [~~submitted separately~~] electronically submitted as an adjustment on the department's web page.

B. SIGNATURE REQUIREMENTS ON WAGE AND CONTRIBUTION REPORTS: Wage and contribution reports must have an appropriate electronic signature by the owner, partner, corporate officer or a designated representative of the employer. If the employer appoints a designated representative or third party agent who is not an employee, [~~a power of attorney authorizing the designated representative to sign the reports must be filed with the department. Unsigned or improperly signed reports that are returned to the employer for proper signature will not be considered valid or filed until they are properly signed and returned to the department~~] the employer must electronically specify what duties have been assigned to the designated representative or third party agent to perform on the employer's behalf.

C. WAGE DETAIL REPORTING REQUIREMENTS: All employers must file their quarterly wage and contribution report electronically, using one of the acceptable formats prescribed by the department or directly on-line. The information provided by the employer as to individual employees shall be on a report form prescribed by the department and shall be entered in the department's records. Reports that contain extraneous information, are incomplete or otherwise submitted or prepared improperly will not be acceptable and will be rejected and become subject to the following penalties:

(1) if the required report for any calendar quarter is not filed within ten (10) days after due date, a penalty of fifty dollars ($50.00) is to be paid by the employer;

(2) if the contributions due on such report are not paid in full within ten (10) days after due date, an additional penalty of five percent but not less than twenty-five dollars ($25.00) is to be paid by the employer on any such contributions remaining unpaid;

(3) if any payment required to be made by the Unemployment Compensation Law (NMSA 1978 51-1-1) is attempted to be made by check which is not paid upon presentment, a penalty of twenty-five dollars ($25.00) shall be paid by the employer; and

(4) in no case shall any penalty as herein provided or as imposed by this section be assessed for any quarter prior to the six completed calendar quarters immediately preceding the quarter in which the employer shall be determined subject to the Unemployment Compensation Law; and in no case shall a penalty for late reporting or late payment of contribution be imposed if, in the opinion of the secretary, an employer's late reporting, late payment of contribution, or both, was occasioned by circumstances beyond the control of the employer, who in good faith exercised reasonable diligence in an effort to comply with the reporting and contribution payment provisions of the Unemployment Compensation Law.

D. ESTIMATED WAGE AND CONTRIBUTION REPORTS: If an employer fails or refuses to make reports in a manner as prescribed in Subsection C of 11.3.401.404 NMAC showing what the employer claims for the amount of contributions which it believes to be due, the department's representative shall estimate the amount according to the process described in Subsection E of 11.3.401.404 NMAC. After the estimated contribution is calculated, the department shall mail a notice to the employer advising it that the department is estimating the amount of contribution due, [~~providing the estimated amount and advising that ten (10) days after the notice is given, the lien will be recorded. After the ten (10) days provided in the notice has elapsed, the lien shall be recorded. Upon issuance, the department shall cause the warrant of levy and lien to be recorded in same manner as any other warrant issued by the department. If the employer does not make a showing to the satisfaction of the secretary that the estimated contribution is incorrect within thirty days after the warrant of levy and lien is filed with the county clerk, then the estimated amount shown in the warrant shall be and become the amount of the contribution due for the period stated in the warrant~~] provide the estimated amount of contribution due and advise the employer that unless an appeal is initiated within fifteen days pursuant to Subsection B of 11.3.500.8 NMAC, the estimated amount shown in the notice shall be the amount of the contribution due for the period stated in the notice. The notice shall also inform the employer that the department may record a lien against the employer's assets. Ten days after sending the notice to the employer the department shall cause the warrant of levy and lien to be recorded in same manner as any other warrant issued by the department. If thereafter, the department should receive from the employer reports for the estimated quarters containing different amounts, the estimation of the contribution due shall not be altered, and the employer shall remain liable for the amount assessed. [~~The information provided by the employer as to individual employees shall be on a report form prescribed by the department and shall be entered in the department's records.~~]

E. ESTIMATION PROCESS: The estimated contribution shall be one and one-half times higher than the highest contribution reported in any quarter in the most recent [~~two years or~~] eight quarters in which wage reports were filed. If no wage and contribution report has been filed since the employer was determined liable or if the employer has never submitted a report to determine liability to the department, no estimations shall be done unless required to clear an unemployment insurance claim.

F. ADMINISTRATIVE ERROR: At any time, the department may correct any error the [~~unemployment insurance assistant bureau chief for the tax section~~] department determines has been made even if notifications have been given, estimations made or contributions paid pursuant to the notifications. By way of example and not by limitation, such internal errors may be the result of an estimation that has been made after notice was mailed to an incorrect address, mailed to a deceased or incapacitated natural employer, estimations otherwise imposed without proper notice to the employer, estimations imposed due to misinformation in a wage claim which precipitated the establishment of an incorrect account, or other incidents of human or computer error or excusable neglect within the department. Estimations may be removed only pursuant to the

written authorization of the [~~unemployment insurance assistant bureau chief for the tax section~~] department.
[7-15-98; 11.3.400.404 NMAC - Rn & A, 11 NMAC 3.400.404, 9-1-2001; A, 01-01-2003; A, 11-15-2012; A, 10-15-2014]

11.3.400.407 FIRST PAYMENT OF CONTRIBUTIONS FOR NEW EMPLOYERS AND EMPLOYERS ELECTING COVERAGE:

A. The first contribution payment of any employing unit which becomes an employer within any calendar quarter of any calendar year shall become due and payable on or before the last day of the month next following the quarter for which such contributions have accrued, and shall include contributions which have accrued during the whole of such calendar year.

B. Notwithstanding the provisions of Subsection A of 11.3.400.407 NMAC [~~of this rule~~], the first contribution payment of any employing unit which elects to become an employer shall, upon the written or electronic approval of the department, become due and payable on or before the last day of the month next following the close of the calendar quarter in which the department's approval is given. Such first payment shall include contributions with respect to all wages for services covered by such election paid on or after the effective date and up to and including the last day of such calendar quarter. Interest and penalties shall be assessed from and after the due date.
[7-15-98; 11.3.400.407 NMAC - Rn & A, 11 NMAC 3.400.407, 9-1-2001; A, 01-01-2003; A, 10-15-2014]

11.3.400.408 PAYMENT OF CONTRIBUTIONS FOR UNCOMPLETED CALENDAR QUARTERS:
Contributions shall be payable for any expired part of an uncompleted calendar quarter with respect to wages for employment in such period in any case where an employer, by reason of the removal from the state, discontinuance, sale, or other transfer of the employer's business has ceased to employ individuals in employment. Such contributions shall become due and payable not later than thirty days after the removal, discontinuance, sale or other transfer of the employer's business; provided that where an application for transfer of the employer's account is filed within said 30-day period, it must be accompanied by all quarterly reports and payments as required by [~~11.3.400.415 and 416 NMAC~~] 11.3.400.415 NMAC and 11.3.400.416 NMAC. Interest shall be assessed from and after said due date. Penalties shall be assessed in accordance with law.
[7-15-98; 11.3.400.408 - Rn, 11 NMAC 3.400.408, 9-1-2001; A, 11-15-2012; A, 10-15-2014]

11.3.400.409 REPORT TO DETERMINE LIABILITY:

A. REGISTRATION: Each employing unit or business entity engaged in doing business in the state of New Mexico, whether by succession to a business already being operated, by starting a new business, by change in partnership, or otherwise, shall [~~file a report to determine liability with the department on a form supplied by the department. Each employing unit shall, within ten days, immediately after beginning such business, inform the department in writing of that fact and request the report to determine liability. The report to determine liability shall be filed within thirty days from the commencement of the business even if the employing unit or business entity does not have employees performing services subject to coverage under the New Mexico Unemployment Compensation Law.~~] register the business on line. Registration for the business may be filed when the employer has hired its first employee, and:

(1) The employer has paid an individual wages of four hundred fifty ($450) dollars or more in any calendar quarter in either the current or preceding calendar year or if there was one or more persons (part-time workers included) in employment in each of twenty different calendar weeks during either the current or the preceding calendar year irrespective of whether the same individual was in employment in each day.

(2) In agricultural labor, the employer has paid wages of twenty thousand ($20,000) dollars or more to individuals during any calendar quarter in either the current or the preceding calendar year or employed ten or more individuals in agricultural labor (part-time workers included) in each of twenty different calendar weeks in either the current or preceding calendar year, whether or not the weeks were consecutive and regardless of whether the individuals were employed at the same time.

(3) The employer has paid an individual in domestic service in a private home, local college club or local chapter of a college fraternity or sorority wages of one thousand ($1,000) dollars in any calendar quarter in the current or preceding calendar year.

B. REPORT OF CHANGE IN STATUS:

(1) Every subject employer who shall sell, convey or otherwise dispose of its business, or all or any substantial part of the assets thereof, or who shall cease business for any reason, whether voluntarily or by being in bankruptcy shall, within five days, immediately report such fact, [~~in writing or~~] electronically, to the department, stating the name and address of the person, firm or corporation to whom such business, or all or any substantial part of the assets thereof, shall have been sold, conveyed or otherwise transferred.

(2) In cases of bankruptcy, receivership or similar situations, such employer shall report the name and address of the trustee, receiver or other official placed in charge of the business.

(3) Upon the death of any employer, the report shall be made by the employer's personal representative upon his appointment by the court. In the event no personal representative is appointed, the report shall be made by the heir or other person who succeeds to the interest of the employer.

(4) In the event of a dissolution of a partnership or joint venture, such report shall be made by the former partners or joint venturers.

(5) For purposes of Paragraph (1) of Subsection B of 11.3.400.409 NMAC [~~of this rule~~], "substantial" part of a business, shall be any identifiable part which, if considered alone, would constitute an employing unit as defined in NMSA 1978 Section 51-1-42D.
[7-15-98; 11.3.400.409 NMAC - Rn & A, 11 NMAC 3.400.409, 9-1-2001; A, 01-01-2003; A, 10-15-2014]

11.3.400.410 EXTENSION OF DUE DATE FOR FILING QUARTERLY REPORTS OR PAYMENT OF CONTRIBUTIONS OR PAYMENTS IN LIEU OF CONTRIBUTIONS: Upon written application to the department establishing to the department's satisfaction that good cause exists therefore, an extension not to exceed thirty (30) days may be granted with respect to the date when the employer's quarterly wage and contribution report or payment of contributions or payments in lieu of contributions shall become due and be paid. Such application must be filed prior to the regular due date. [~~For purposes of 11.3.400.410 NMAC, "good cause" means unavoidable circumstances which render the employer's records incomplete or inaccessible for the preparation of the report and computation of the contributions due within the time otherwise prescribed and it shall not include any dilatory act or negligence by the employer.~~]
[7-15-98; 11.3.400.410 NMAC - Rn & A, 11 NMAC 3.400.410, 9-1-2001; A, 11-15-2012; A, 10-15-2014]

11.3.400.415 EXPERIENCE RATING OF EMPLOYERS: This rule shall govern the experience rating provisions of NMSA 1978 Section 51-1-11.

A. [~~DEFINITIONS: For purposes of 11.3.400.415 NMAC, the following definitions shall apply:~~

~~(1) The "total assets in the fund" means all contributions collected, (except those contributions collected pursuant to contribution schedule B of NMSA 1978 Section 51-1-11), all payments in lieu of contributions collected or due from nonprofit organizations or governmental units and accounts receivable for federal shareable benefits for periods through the computation date of June 30.~~

~~(2) "Last annual payrolls" means the total payrolls as reported by all employers subject to contributions for the twelve-month period ending December 31 prior to the computation date.~~

~~(3) The "employer reserve" for each employer shall be the excess of employer's total contributions paid less total benefit charges computed as a percentage of the employer's "average payroll" reported for contributions. The "employer reserve" total contributions for each employer shall not include payments made pursuant to contribution schedule B of NMSA 1978 Section 51-1-11. Each "employer reserve" account percentage shall be rounded to the nearest one-tenth of one percent.~~

~~(4) Payments made pursuant to contribution schedule B of NMSA 1978 Section 51-1-11 are not reportable for Federal Unemployment Tax Act (FUTA) tax credit purposes and are not considered in the calculation to determine the "employer reserve."~~

~~B.~~] ELIGIBILITY OF EMPLOYER'S ACCOUNT FOR COMPUTED RATE BASED ON BENEFIT EXPERIENCE. For purposes of the interpretation and application of NMSA 1978 [~~Section 51-1-11E~~] Section 51-1-11(D), no employer's experience rating account shall be deemed to have been chargeable with benefits throughout the preceding [~~thirty-six~~] twenty-four consecutive calendar month period ending on a computation date as defined in NMSA 1978 [~~Section 51-1-11H(3)(d)~~] Section 51-1-11O(5), unless as of such computation date, the department finds that the employer paid wages in employment during any part of the first calendar quarter of the [~~three and one-half year~~] twenty-four month period ending on such computation date and that the payment of such wages was not interrupted for [~~nine~~] eight or more consecutive calendar quarters, or by termination of coverage under NMSA 1978 Section 51-1-18; provided, all quarterly wage and contribution reports received by the department by July 31 following the computation date will be considered in computing the rate for the succeeding calendar year.

B. CONTRIBUTING EMPLOYERS FOR TWENTY-FOUR MONTHS. For each calendar year, if, as of the computation date of that year, an employer has been a contributing employer throughout the preceding twenty-four months, the contribution rate for that employer shall be determined by multiplying the employer's benefit ratio by the reserve factor as determined pursuant to 11.3.400.427 NMAC; provided that an employer's contribution rate shall not be less than thirty-three hundredths percent or more than five and four-tenths percent. An employer's benefit ratio is determined by dividing the employer's benefit charges during the immediately preceding fiscal years, up to a maximum of three fiscal years, by the total of the annual payrolls of the same time period, calculated to four decimal places, disregarding any remaining fraction.

C. CONTRIBUTING EMPLOYERS FOR LESS THAN TWENTY-FOUR MONTHS. For each calendar year, if, as of the computation date of that year, an employer has been a contributing employer for less than twenty-four months, the contribution rate for that employer shall be the average of the contribution rates for all contributing employers in the employer's industry, pursuant to 11.3.400.427 NMAC, but shall not be less than one percent or more than five and four-tenths percent; provided that an individual, type of organization or employing unit that acquires all or part of a employing enterprise that has a rate of contribution less than the average of the contribution rates for all contributing employers in the employer's industry, shall be entitled to the transfer of the contribution rate of the other employing unit to the extent permitted pursuant to Subsection D of 11.3.400.417 NMAC.

D. EXCESS CLAIMS PREMIUM. If an employer's contribution rate pursuant to Subsection B of 11.3.400.415 NMAC is calculated to be greater than five and four-tenths percent, notwithstanding the limitation in Subsection B of 11.3.400.415 NMAC, the employer shall be charged an excess claims premium in addition to the contribution rate applicable to the employer; provided that an employer's excess claims premium shall not exceed one percent of the employer's annual payroll. The excess claims premium shall be determined by multiplying the employer's excess claims rate by the employer's annual payroll. An employer's excess claims rate shall be determined by multiplying the difference of the employer's contribution rate, notwithstanding the limitation in Subsection B of 11.3.400.415 NMAC, less five and four-tenths percent by ten percent.

E. NOTIFICATION OF ANNUAL RATE CONTRIBUTIONS. The department shall promptly notify each employer of the employer's rate of contributions and excess claims premium as determined for any calendar year on or before January 31st of the year the rate is effective. Such notification shall include the amount determined as the employer's annual payroll and total benefits charged to the employer for at least two years, but not to exceed three years. For an employer that has been a contributing employer for less than twenty-four months, the contribution rate for that employer shall be the average of the contribution rates for all contributing employers in the employer's industry as set forth in Subsection C of 11.3.400.415 NMAC. Such determination shall become conclusive and binding upon the employer unless, within thirty days after the delivery or mailing of notice thereof to the employer's last known address, the employer files an appeal pursuant to Subsection B of 11.3.500.8 NMAC. The employer shall not have standing, in any appeal involving the employer's rate of contributions or contribution liability, to contest the chargeability to the employer of any benefits paid in accordance with a decision pursuant to NMSA 1978 Section 51-1-8 , except upon the ground that the services on the basis of which such benefits were found to be chargeable did not constitute services performed in employment for the employer and only in the event that the employer was not a party to the decision, or to any other proceedings under the Unemployment Compensation Law in which the character of such services was determined.

F. NOTIFICATION OF QUARTERLY CHARGES. The department shall provide each contributing employer a written determination of benefits chargeable to the employer within ninety days of the end of each calendar quarter. Such determination shall become conclusive and binding upon the employer unless, within thirty days after the delivery or mailing of the written determination to the employer's last known address, the employer files an appeal of the determination pursuant to Subsection B of 11.3.500.8 NMAC. The employer shall not have standing, in any appeal involving the employer's quarterly rate of contributions or contribution liability, to contest the chargeability to the employer of any benefits paid in accordance with a decision pursuant to NMSA 1978 Section 51-1-8 , except upon the ground that the services on the basis of which

such benefits were found to be chargeable did not constitute services performed in employment for the employer and only in the event that the employer was not a party to the decision, or to any other proceedings under the Unemployment Compensation Law in which the character of such services was determined.

[07-15-98; 11.3.400.415 NMAC - Rn & A, 11 NMAC 3.400.415, 09-01-2001; A, 01-01-2003; A, 08-27-2003; A, 07-16-2007; A, 11-15-2012; A, 10-15-2014]

11.3.400.416 BUSINESS TRANSFERS DEFINED; EFFECTIVE DATE: It is deemed that two or more employing units are parties to or the subject of a business transfer transaction whenever one such unit acquires an employing enterprise from another such unit, either by merger, consolidation or other form of reorganization; by a contractual or other form of voluntary sale or transfer; or by a transfer by order of court. There is a transfer and an acquisition in this sense, not only where there is an outright sale between separate individuals or concerns, but also where individuals form partnerships or corporations; partnerships form into corporations; new partnerships are formed by the addition or withdrawal of members; a corporation officer or partner acquires the enterprise from the corporation or the partnership; or in any manner that a change is made in the identity or organization of the employing unit. The effective date of such an acquisition and transfer is the date [~~when~~] the department determines that the change in ownership or possession and operation is actually consummated as evidenced by a bill of sale, deed to real estate and buildings, a transfer by any other form of written transfer agreement or legally valid instrument, transfer by court order, or by physical or constructive possession.

[7-15-98; 11.3.400.416 NMAC - Rn, 11 NMAC 3.400.416, 9-1-2001; A, 10-15-2014]

11.3.400.417 EXPERIENCE HISTORY TRANSFERS:

A. TOTAL EXPERIENCE HISTORY TRANSFERS:

(1) ACQUISITION OF ALL EMPLOYING ENTERPRISES: A total experience history transfer is available to a successor enterprise only in the situation where the successor has acquired all of the predecessor's business enterprise and, where the predecessor, immediately after the business transfer as defined in 11.3.400.416 NMAC, ceases operating the same enterprise except for liquidation purposes.

(a) In the sale of a business enterprise, the phrase "all assets" includes the transfer of a favorable experience history.

(b) In the sale of a business enterprise, the phrase assumption of "all liabilities" includes an unfavorable experience history and any unpaid contributions.

(2) NOTIFICATION BY SUCCESSOR: A successor who has acquired all of the predecessor's employing enterprises shall notify the department of such acquisition [~~, in writing,~~] by completing an electronic application for a total experience history transfer on the department's webpage sixty (60) days on or before the due date of the successor's first quarterly wage and contribution report after the effective date of the acquisition of the employing enterprise or enterprises. Information with respect to the predecessor and successor employing enterprises necessary to a department determination to approve or disapprove a total history transfer shall be given as prescribed by the electronic application on the department's webpage or as requested by the department. Upon [~~receipt of such notification,~~] completion of an application, the department shall furnish a statement of account to the predecessor and the successor, if the predecessor is delinquent in either submitting wage and contribution reports or the payment of contributions.

(a) [~~A successor who has acquired all of the predecessor's employing enterprises shall notify the department of such acquisition, in writing, on or before the due date of the successor's first quarterly wage and contribution report after the effective date of the acquisition of the employing enterprise or enterprises.~~] All contributions, interest and penalties due from the predecessor employer must be paid.

(b) If the successor employer fails to [~~notify the department~~] complete an electronic application to the department [~~on or~~] before the due date of the successor's first quarterly wage and contribution report after the effective date of the acquisition, when the department receives actual notice of the transfer, the department shall effect the transfer [~~and shall impose a penalty of $50.00 upon the successor~~] of the experience history and applicable rate of contribution retroactively to the date of the acquisition and the successor shall pay a penalty of fifty ($50.00) dollars.

(c) [~~Notice of the transfer must be received by the department~~] An electronic application for a history transfer must be completed on line during the calendar year of the transaction transferring the employing enterprises. Upon a showing of good cause, the department may extend the due date for the completion of the endorsed application and quarterly wage and contribution reports for an additional thirty days provided that the request for an extension of time is filed in writing on or before the regular due date.

(3) LIQUIDATION WAGES: [~~Liquidation~~] Any wages reported by the predecessor and contributions paid by the predecessor for [~~liquidation wages~~] the cessation of the predecessor's business after the acquisition date of the business by the successor shall be credited to the successor's account for experience rating purposes.

(4) WRITTEN DETERMINATION TO SUCCESSOR AND PREDECESSOR: The department shall issue a written determination to the successor and predecessor approving or disapproving the total history transfer. All such determinations shall be subject to the provisions of [~~11.3.500.512~~] 11.3.500.8 NMAC governing appeals of contribution or tax determinations. Failure to timely appeal a denial of the transfer of a favorable experience transfer without good cause as [~~provided in 11.3.400.417 NMAC~~] defined in11.3.400.7 NMAC will deprive the successor business of the opportunity for the transfer of the favorable experience history transfer.

(5) PREDECESSOR RESUMES OR CONTINUES IN BUSINESS: If the predecessor owner operates a new or different business enterprise upon or after the business transfer, the predecessor shall be assigned a new account number and a standard rate in accordance with the provisions of NMSA 1978 Section 51-1-11[E].

[~~B. OUT-OF-STATE EXPERIENCE HISTORY TRANSFERS, PROCEDURE:~~

~~(1) An employing enterprise moving a business into New Mexico; the "out-of-state entity" may seek a transfer of the enterprise's experience history from the predecessor state.~~

~~(2) At any time during the application process, until the close of the 15 day appeal period after determination, the employing enterprise may withdraw its application for an out-of-state history transfer and accept New Mexico rate for new businesses.~~

~~(3) Upon making application for an out-of-state experience rate transfer, the employing enterprise will temporarily be issued a standard rate in accordance with the provisions of NMSA 1978 Section 51-1-11E until the out-of-state experience history transfer is completed.~~

~~(4) The initial registration must specify that the employing enterprise seeks an out-of-state experience~~

~~history transfer. No retroactive requests will be entertained.~~

~~(5) The initial registration and application must be made within 30 days of commencing business within the state of New Mexico.~~

~~(6) To be eligible for the out-of-state transfer, the employing enterprise must have been in operation for at least three full calendar years in the predecessor state.~~

~~(7) The out-of-state employing enterprise must physically close its operation in entirety in the predecessor state and complete all liquidation within six months of opening the New Mexico operation.~~

~~(8) The business enterprise opened in New Mexico must be of the same type and nature as the enterprise operated in the predecessor state.~~

~~(9) If the entity owning the business enterprise maintains other businesses in the predecessor state, only the experience history attributable to the enterprise actually relocated to New Mexico may be transferred.~~

~~(10) Within 20 days of submitting the application for an out-of-state experience history transfer, the employing enterprise shall submit a full and complete account history for at least the immediate three calendar years. This history must include:~~

~~(a) the number of workers laid off at the time the out-of-state entity closed its operation in the predecessor state;~~

~~(b) the nature of the business being transferred including a statement demonstrating that the out-of-state enterprise and the proposed New Mexico enterprise are of the same nature and type;~~

~~(c) copies of the periodic wage reports submitted to the predecessor state for at least three full calendar years plus the current year immediately preceding the transfer application.~~

~~(11) The account history must be validated, certified and exemplified by the monitoring agency of the predecessor state where the wages were reported; it shall include certified copies of tax rate notices from the predecessor state for each of the last four years in which the employing enterprise was in business in the predecessor state.~~

~~(12) The account history shall include benefits paid and charged or non-charged and be based on wages paid prior to the transfer. The charges and non-charges shall be transferred to the New Mexico account history.~~

~~(13) The out-of-state employing enterprise must provide documentation, verified by counterpart agency in the predecessor state, comparable to the New Mexico department of labor workforce solutions, that the employing enterprise has no taxes, interest, penalties or other fees due.~~

~~(14) When transferring from a non-reserve ratio state, the out-of-state employing enterprise transferring must provide entire history record.~~

~~(15) From the department's approved list, the employing enterprise shall engage an independent accounting firm to convert the transferred history into the factors used to measure experience in New Mexico.~~

~~(16) The transferred and converted experience history may be accepted by the department but is subject to audit by the department either before the transfer is approved or up to one year after the transfer is approved.~~

~~(17) To be eligible for a reduced rate, a employing enterprise must have been in operation for at least four complete calendar years plus the current year. If an out-of-state employing enterprise applying for a transfer has been in operation for at least three, but not four full calendar years, in the predecessor state, the record from the predecessor state may be transferred, but a reduced rate will not be available until the employing enterprise has been in business for four full calendar years, combining the time in business in the predecessor state and in New Mexico.~~

~~(18) Notification to the other state and treatment of account history: Upon acceptance of the transfer application, the department will notify its counterpart agency in the predecessor state of the acceptance of the transfer application.~~

~~(19) Upon approval of the experience history transfer, the employing entity's contribution rate will be adjusted retroactively to the appropriate rate.~~

~~(20) After receiving notification of the approved transfer, the employing enterprise must submit an updated status report in the form designated by the department within 30 days.~~

~~(21) The provisions of this sub-section apply to all out-of-state transfer requests filed on or after January 1, 2004.~~

~~C.~~] B. PARTIAL EXPERIENCE HISTORY TRANSFERS:

(1) NOTIFICATION BY SUCCESSOR AND SUBMISSION OF JOINT APPLICATION FORM: [~~A successor entity acquiring one or more, but less than all of the employing enterprises of a predecessor entity, shall notify the department of such acquisition, in writing, on or before the due date of the successor's first quarterly wage and contribution report after the effective date of the acquisition of the employing enterprise. Upon receipt of such notification, the department shall furnish the prescribed application form. The application shall be endorsed by the predecessor. The endorsed application and quarterly wage and contribution reports for each calendar quarter involved in the transfer must be filed with the department within thirty days from the date of delivery or mailing of the application by the department. Upon a showing of good cause, the assistant unemployment insurance bureau chief for the tax section may extend the due date for the filing of the endorsed application and quarterly wage and contribution reports for an additional thirty days provided that the request for an extension of time is filed in writing on or before the regular due date. For purposes of Paragraph (1) of Subsection C of 11.3.400.417 NMAC, "good cause" means unavoidable circumstances which renders the predecessor employing enterprise's records incomplete or inaccessible for the preparation of the endorsed application and quarterly wage and contribution reports within the time otherwise prescribed and "good cause" shall not include any dilatory act or negligence by the employer. Information with respect to the predecessor and successor employing enterprises necessary to a department determination of the existence of all of the facts requisite to department approval or disapproval shall be given as prescribed by such forms or as requested by the department. Employers shall have the right to a seated interview at the local workforce development center or the state office where they will be provided assistance as necessary to complete the application.~~] The applicable experience history may be transferred to the successor in the case of a partial transfer of an employing enterprise if the successor has acquired one or more of the several employing enterprises of a predecessor but not all of the employing enterprises of the predecessor and each employing enterprise so acquired was operated by the predecessor as a separate store, factory, shop or other separate employing enterprise and the predecessor, throughout the entire period of the contribution with liability applicable to each enterprise transferred, has maintained and preserved payroll records that, together with records of contribution liability and benefit chargeability, can be separated by the parties from the enterprises retained by the predecessor to the satisfaction of the secretary or the secretary's designee.

(2) The successor shall notify the department of such acquisition by completing an electronic

application for a partial experience history transfer on the department's webpage sixty (60) days on or before the due date of the successor's first quarterly wage and contribution report after the effective date of the acquisition of the employing enterprise. The application shall be endorsed by the predecessor. The application shall provide a schedule of the name and social security number of and the wages paid to and the contributions paid for each employee for the three and one-half year period preceding the computation date through the date of transfer or such lesser period as the enterprises transferred may have been in operation. The application shall be supported by the predecessor's permanent employment records, which shall be available for audit by the department. The application shall be reviewed by the department and, upon approval the percentage of the predecessor's experience history attributable to the enterprises transferred shall be transferred to the successor. The percentage shall be obtained by dividing the taxable payrolls of the transferred enterprises for such three and one-half year period preceding the date of computation or such lesser period as the enterprises transferred may have been in operation, by the predecessor's entire payroll. Upon a showing of good cause as defined in 11.3.400.7 NMAC, the department may extend the due date for the filing of the endorsed application and quarterly wage and contribution reports for an additional thirty days provided that the request for an extension of time is filed in writing on or before the regular due date. Information with respect to the predecessor and successor employing enterprises necessary to a department determination to approve or disapprove a partial history transfer shall be given as prescribed by the application or as requested by the department.

[~~(2)~~] (3) WRITTEN DETERMINATION TO SUCCESSOR: The department shall issue a written determination to the successor approving or disapproving the partial history transfer. All determinations disapproving the partial history transfer shall be subject to the provisions of [~~11.3.500.512 NMAC~~] 11.3.500.8 NMAC governing appeals of contribution or tax determinations. Failure to timely appeal a denial of the partial history transfer without good cause as defined in 11.3.400.7 NMAC will deprive the successor business of the opportunity for the transfer of the partial history experience.

C. COMMON OWNERSHIP EXPERIENCE HISTORY TRANSFER:

(1) If the transaction involves only a merger, consolidation or other form of reorganization without a substantial change in the ownership and controlling interest of the business entity, as determined by the secretary, and both the predecessor and the successor are under common ownership, a party to a merger, consolidation or other form of reorganization shall not be relieved of liability for any contributions, interest or penalties due and owing from the employing enterprise at the time of the merger, consolidation or other form of reorganization.

(2) The experience history attributable to the transferred business shall also be transferred to and combined with the experience history attributable to the successor employer. The rates of both employers shall be recalculated and made effective immediately upon the date of the transfer.

D. DETERMINATION OF CONTRIBUTION RATES AFTER TOTAL OR PARTIAL EXPERIENCE HISTORY TRANSFER: [~~For the period from the effective date of the transfer to the following January 1, the rate shall be determined as follows:~~

~~(1) If the successor is a liable employer and rated for the calendar year on the effective date of the transfer, there will be no change in rate determined for the successor's account as a result of the transfer.~~

~~(2) If the successor is a liable employer and has not been rated during the calendar year in which the transfer occurred, the rate shall be computed from the successor's prior history combined with the acquired total or partial history.~~

~~(3) If the successor is not a liable employer on the effective date and a new account is established:~~

~~(a) the rate of the predecessor or combined predecessors will apply to the new account in the case of a total experience transfer; and~~

~~(b) a rate based on experience of the separate schedule of employment and related benefits charged will apply to the new account in the case of a partial experience transfer.~~

~~(4) A new rate based on experience of the remaining schedule of employment and related benefits charged will apply to the predecessor account from the effective date of the transfer to current year in the case of a partial experience transfer.~~]

(1) If, on the effective date of the transfer, the successor employer has a contribution rating for the calendar year there will be no change in rate determined for the successor's account as a result of the transfer.

(2) If, on the effective date of the transfer, the successor employer does not have a contribution rating for the calendar year, the rate shall be computed from the successor's prior history combined with the acquired total or partial history of the predecessor.

(3) If, on the effective date of the transfer, the successor employer has not been a contributing employer throughout the preceding twenty-four months, the contribution rate for the successor employer shall be:

(a) the rate of the predecessor or combined predecessors in the case of a total experience transfer; and

(b) a rate based on experience of the separate schedule of employment and related benefits charged will apply in the case of a partial experience transfer.

(4) If, on the effective date of the transfer, the successor employer has not been a contributing employer throughout the preceding twenty-four months, and the successor employer acquires all or part of a employing enterprise that has a rate of contribution less than the average of the contribution rates for all contributing employers in the employer's industry, shall be entitled to the transfer of the contribution rate of the predecessor employing enterprise.

(5) A new rate based on experience of the remaining schedule of employment and related benefits charged will apply to the predecessor account from the effective date of the transfer in the case of a partial experience transfer.

E. CHARGING OF BENEFITS AFTER TRANSFER: Benefits paid subsequent to the effective date of a [~~partial or total~~] partial, total or common ownership experience history transfer shall be charged to the successor's account if the base period wages were transferred to the successor.

[07-15-98; 11.3.400.417 NMAC - Rn & A, 11 NMAC 3.400.417, 09-1-2001; A, 07-01-2003; A, 07-16-2007; A, 11-15-2012; A, 10-15-2014]

11.3.400.418 TIME FOR CORRECTION OF ERRONEOUS RATE DETERMINATIONS:

A. Where an employer's rate of contribution for any calendar year has been incorrectly determined, the error or omission shall be corrected and the rate adjusted accordingly by the department on its own initiative with notification to the employer at its last known address, within the following periods:

(1) on or before June 30 of the calendar year in which the erroneous rate determination was issued if the error was in the determination of benefits chargeable to the employer's experience rating account;

(2) at any time within the calendar year in which the erroneous rate determination was issued if the error or omission was due to the employer's misrepresentation or nondisclosure of a material fact;

(3) at any time during the calendar year in which the erroneous rate determination was issued and any time within the next calendar year if the error or omission was due wholly or in part to a rate computation.

B. Upon issuance of a corrected rate of contribution, the employer shall have the right to a review and redetermination as provided in NMSA 1978 Section 51-1-11[~~(I)~~] (J).

[7-15-98; 11.3.400.418 NMAC - Rn, 11 NMAC 3.400.418, 9-1-2001; A, 10-15-2014]

11.3.400.420 EMPLOYER ELECTIONS TO COVER MULTI-STATE WORKERS:

A. This rule shall govern the department in its administrative cooperation with other states subscribing to the interstate reciprocal coverage arrangement, hereinafter referred to as "the arrangement".

[~~B. As used in 11.3.400.420 NMAC the following words and terms shall have the following meaning, unless the context clearly indicates otherwise:~~

~~(1) "Agency": Any officer, board, commission, or other authority charged with the administration of the unemployment compensation law of a participating jurisdiction.~~

~~(2) "Interested jurisdiction": Any participating jurisdiction to which an election submitted under this rule is sent for its approval; and "interested agency" means the agency of such jurisdiction.~~

~~(3) "Jurisdiction": Any state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, or, with respect to the federal government, the coverage of any federal unemployment compensation law.~~

~~(4) "Participating jurisdiction": A jurisdiction whose administrative agency has subscribed to the arrangement and whose adherence thereto has not terminated.~~

~~(5) "Services customarily performed by an individual in more than one jurisdiction" are services performed in more than one jurisdiction during a reasonable period, if the nature of the services gives reasonable assurance that they will continue to be performed in more than one jurisdiction or if such services are required or expected to be performed in more than one jurisdiction under the election.~~]

[~~C~~] B. Submission and approval of coverage elections under the arrangement.

(1) Any employing unit may file an election, on a form provided by the division, to cover under the law of a single participating jurisdiction all of the services performed for the employer by any individual who customarily works for the employer in more than one participating jurisdiction.

(2) Such an election may be filed, with respect to an individual, with any participating jurisdiction in which:

(a) any part of the individual's services is performed;

(b) the individual resides; or

(c) the employing unit maintains a place of business to which the individual's services bear a reasonable relation.

(3) The agency of the elected jurisdiction shall initially approve or disapprove the election.

(4) If such agency approves the election, it shall forward a copy thereof to the agency of each other participating jurisdiction specified thereon, under whose unemployment compensation law the individual or individuals in question might, in the absence of such election, be covered. Each such interested agency shall approve or disapprove the election, as promptly as practicable; and shall notify the agency of the elected jurisdiction accordingly.

(5) In case its law so requires, any such interested agency may, before taking such action, require from the electing employing unit satisfactory evidence that the affected employees have been notified of, and have acquiesced in, the election.

(6) If the agency of the elected jurisdiction, or the agency of any interested jurisdiction, disapproves the election, the disapproving agency shall notify the elected jurisdiction and the electing employing unit of its action and of its reason therefore.

(7) Such an election shall take effect as to the elected jurisdiction only if approved by its agency and by one or more interested agencies.

(8) An election thus approved shall take effect, as to any interested agency, only if it is approved by such agency.

(9) In case any such election is approved only in part, or is disapproved by some of such agencies, the electing employing unit may withdraw its election within ten days after being notified of such action.

[~~D~~] C. Effective period of elections.

(1) Commencement.

(a) An election duly approved under this rule shall become effective at the beginning of the calendar quarter in which the election was submitted, unless the election, as approved, specified the beginning of a different calendar quarter.

(b) If the electing unit requests an earlier effective date than the beginning of the calendar quarter in which the election is submitted, such earlier date may be approved solely as to those interested jurisdictions in which the employer had no liability to pay contributions for the earlier period in question.

(2) Termination.

(a) The application of an election to any individual under this rule shall terminate, if the agency of the elected jurisdiction finds that the nature of the services customarily performed by the individual for the electing unit has changed, so that they are no longer customarily performed in more than one participating jurisdiction. Such termination shall be effective as of the close of the calendar quarter in which notice of such finding is mailed to all parties affected.

(b) Except as provided in Subparagraph (a) of Paragraph (2) of Subsection D of 11.3.400.420 NMAC, each approved election shall remain in effect through the close of the calendar year in which it is submitted, and thereafter until the close of the calendar quarter in which the electing unit gives written notice of its termination to all affected agencies.

(c) Whenever an election hereunder ceases to apply to any individual, under Subparagraph (a) of Paragraph (2) of Subsection D of 11.3.400.420 NMAC, the electing unit shall notify the affected individual accordingly.

[~~E~~] D. Reports and notices by the electing unit.

(1) The electing unit shall promptly notify each individual affected by its approved election, on a form approved by the elected jurisdiction, and shall furnish the elected agency a copy of such notice.

(2) Whenever an individual covered by an election hereunder is separated from the individual's employment, the electing unit shall again

notify the individual, forthwith, as to the jurisdiction under whose unemployment compensation law the individual's services have been covered. If at the time of termination the individual is not located in the elected jurisdiction, the electing unit shall notify the individual as to the procedure for filing interstate benefit claims.

(3) The electing unit shall immediately report to the elected jurisdiction any change which occurs in the conditions of employment pertinent to its election, such as cases where an individual's services for the employer cease to be customarily performed in more than one participating jurisdiction or where a change in the work assigned to an individual requires the individual to perform services in a new participating jurisdiction.

[~~F~~] E. Approval of reciprocal coverage elections. The authority to approve or disapprove reciprocal coverage elections in accordance with this rule shall be exercised by the [~~assistant unemployment insurance bureau chief for the tax section~~] secretary or the secretary's designee.

[7-15-98; 11.3.400.420 NMAC - Rn & A, 11 NMAC 3.400.420, 9-1-2001; A, 01-01-2003; A, 11-15-2012; A, 10-15-2014]

11.3.400.421 EMPLOYERS ELECTING COST BASIS FINANCING AND GROUP ACCOUNTS:

A. [~~DEFINITIONS. Where used in 11.3.400.421 NMAC words and phrases shall have the following meanings, unless otherwise indicated:~~

~~(1) "Account" means the employer account, identified by an account number, established and maintained for each employer, or employer member of a group account, for the purpose of determining liability for payments in lieu of contributions, and from which benefits to eligible claimants can be determined.~~

~~(2) "Group account" means the account, identified by an account number, established for two or more employers whose application to become liable for payments in lieu of contributions and for sharing the cost of benefits paid by them, has been approved by the department in accordance with NMSA 1978 Section 51-1-13E.~~

~~(3) "Group member" means any employer who has become associated with another or others to form a group account.~~

~~(4) "Taxable year" means the calendar year beginning the first day of January and ending the thirty-first day of December.~~

~~B.~~] CHARGING OF BENEFITS: Any benefits or any portion thereof, paid on the basis of wage credits earned within the claimant's base period with any employer who has elected to become liable for payments in lieu of contributions, shall be reimbursed by the employer in accordance with NMSA 1978 Section 51-1-13B(4), and any benefits or portion thereof, paid on the basis of wage credits earned within the claimant's base period with any employer while the employer was subject to contributions pursuant to NMSA 1978 Section 51-1-18A, shall be charged to the experience rating account of the employer as provided in NMSA 1978 Section 51-1-11B.

[~~C~~] B. DUE DATES OF WAGE AND CONTRIBUTION REPORTS AND PAYMENTS IN LIEU OF CONTRIBUTIONS: Each employer who has elected to become liable for payments in lieu of contributions shall submit a wage and contribution report [~~on a form prescribed by the department~~] electronically to the department each calendar quarter with respect to wages paid in such quarter. Said wage and contribution report shall be submitted on or before the end of the month following the close of the calendar quarter to which the wage and contribution report applies. The wages so reported shall not be used for computation of rates as provided for employers subject to contributions.

[~~D~~] C. SUBMISSION OF WAGE AND CONTRIBUTION REPORTS FOR GROUP ACCOUNTS: The quarterly wage and contribution report required of each group member of a group account shall be transmitted electronically by the group representative [~~with a statement listing each wage and contribution report and showing total wages paid by each group member~~]. The payments in lieu of contributions required of each group member shall be transmitted by the group representative, together with all amounts owing by all the group members, within thirty days after transmission by the department of a statement showing the payments in lieu of contributions owing. Each report and any payments required of each employer or group member not transmitted within the time specified will be delinquent and penalties and interest as provided by the Unemployment Compensation Law shall be assessed from and after the delinquent date.

[~~E~~] D. EXTENSION OF TIME TO SUBMIT REPORTS: Upon written application, transmitted prior to the due date, by an employer, group member, or group account representative establishing to the satisfaction of the department that good cause exists, excluding any dilatory act, negligence or lack of funds on the part of the employer, an extension, not to exceed thirty days, may be granted by the department with respect to the due date of the wage and contribution report or payment.

[~~F~~] E. TERMINATION OF RIGHT TO MAKE PAYMENTS IN LIEU OF CONTRIBUTIONS: If, after due notice, any employer who has elected to become liable for payments in lieu of contributions remains delinquent for payments or interest or penalty, the department shall transmit a determination to said employer of pending termination of the organization's election to make payments in lieu of contributions for the next calendar year. If payment is not forthcoming within thirty days from the date of said notice, the department shall transmit a final determination to such employer that election has been terminated for the next calendar year.

[~~G~~] F. REQUIREMENTS FOR SURETY BOND: At the discretion of the department, termination of an organization's election to make payments in lieu of contributions shall continue effective for any succeeding calendar year unless the employer provides a surety bond acceptable to the department and underwritten by a corporate surety authorized to transact business in New Mexico; or an agreement of cash collateral assignment, executed with a state or national bank or federally insured savings association authorized to do business in New Mexico, as trustee, in a form prescribed by the department. Interest, if any, accumulating on the cash collateral assignment shall accrue to the employer. Said surety or cash bond shall be in the amount of not more than 2.7% of the taxable wages paid for employment subject to the Unemployment Compensation Law by the employer in the four quarter period immediately preceding the date of notice of termination was issued and shall be released by the department only when no further delinquency for payment in lieu of contributions of the employer exists.

[~~H~~] G. ESTABLISHING ACCOUNTS, PROVIDING FOR ADDITIONS AND WITHDRAWALS OF GROUP MEMBERS: The department, upon receipt of properly completed form prescribed by the department bearing the endorsement of each group member, accompanied by any forms enumerated therein or otherwise requested in writing, shall establish a group account and notify the group representative of the effective date as provided in NMSA 1978 Section 51-1-13E. The group account shall remain in effect for a period of not less than two calendar years, ending on December 31, and thereafter, until terminated at the discretion of the department, or by approval by the department, of an application from the group received on or before December 1, immediately preceding the calendar year in which termination is desired. Upon establishment and after termination of the group account, each group member, group account and group account representative

shall be fully liable for:

(1) any payment in lieu of contributions, penalties or interest required under NMSA 1978 Section 51-1-13E, for the period during which any benefits or portion thereof are payable on the basis of wage credits earned during the period the claimant's base period employer was a group member; and

(2) the performance of the group representative.

[~~I~~] H. ADDITIONS OF GROUP MEMBERS: Any nonprofit organization liable for payments in lieu of contributions which becomes subject to the Unemployment Compensation Law on or after January 1, 1972, may, with the approval of the department, be added to an existing group account if the department receives an application as called for in Subsection H of 11.3.400.421 NMAC not later than thirty days prior to the beginning of the calendar year for which the application is to be effective.

[~~J~~] I. ACQUISITION OF GROUP MEMBERS: Any nonprofit organization liable for payments in lieu of contributions which acquired the organization, trade or business, or substantially all the assets thereof, of a group member who because of the transaction no longer employs workers in employment will be a group member of the group account to which [~~his~~] the predecessor belonged provided the department receives an application as called for in Subsection H of 11.3.400.421 NMAC not later than thirty (30) days after the date of the transaction.

[~~K~~] J. WITHDRAWAL OF GROUP MEMBERS: A member may withdraw or be removed from a group account only at the end of a calendar year provided written application for withdrawal or removal is received by the department not later than thirty days prior to the first day of the following calendar year. Such withdrawal or removal of a member from a group account shall not be effective until approved by the department. No group member may withdraw or be removed from a group account unless it has been a member of such group account for at least two calendar years as of the effective date of the withdrawal or removal; except that a member may withdraw or be removed from a group at any time if the group member:

(1) has permanently ceased to employ workers in employment; or

(2) has ceased to be an employer exempt under Section 3306 (c) (8) of the federal Unemployment Tax Act; or

(3) has, in accordance with NMSA 1978 Section 51-1-13A (2), terminated its election to be liable for payments in lieu of contributions; or

(4) has for a period of two successive quarters been delinquent in its payment of assessments under the group plan for benefits chargeable to its account.

[7-15-98; 11.3.400.421 NMAC - Rn & A, 11 NMAC 3.400.421, 9-1-2001; A, 01-01-2003; A, 11-15-2012; A, 10-15-2014]

11.3.400.422 INDIAN TRIBES:

A. ELECTION OF TREATMENT:

(1) An Indian tribe, tribal unit or a subdivision, subsidiary or business enterprise wholly owned by a tribe ("electing entity") shall make its election to be a contributing employer or reimbursable employer on or before December 1, for previously registered Indian tribes, and 30 days after subjectivity is determined for newly subject Indian tribes, except for the year 2001, Indian tribes may make the election any time between July 1, 2001, and December 1, 2001. If the electing entity fails to make an affirmative election in writing in the manner provided in [~~11.3.400 NMAC~~] 11.3.400.422 NMAC, the electing entity shall be deemed to have elected status as a contributing employer.

(2) If the Indian tribe, tribal unit or a subdivision, subsidiary or business enterprise wholly owned by a tribe is currently registered with the department and desires to change its manner of treatment, the electing entity may change its election on or before the due date of the wage and contribution report for the fourth quarter of 2001, which report is due January 31, 2002. Such change in election shall be in writing in the manner provided in 11.3.400.422 NMAC

B. MASTER CONTRIBUTORY ACCOUNTS:

(1) Effective July 1, 2001, master contributory accounts for the Indian tribe, tribal unit or a subdivision, subsidiary or business enterprise wholly owned by a tribe previously established with the department are discontinued. If the Indian tribe, tribal unit or a subdivision, subsidiary or business enterprise wholly owned by a tribe elects to be a reimbursable employer, it may apply for group account treatment as provided in 11.3.400.421 NMAC.

(2) Upon the termination of a master account, all members of the master account will be assigned the then existing tax rate for the master account. Each member of the former master account will enjoy the former master account's tax rate for the remainder of the calendar year 2001. Thereafter, each former member of the former master account will be assigned an individual tax rate based on its individual experience history commencing July 1, 2001.

C. ASSIGNMENT OF ACCOUNT NUMBERS:

(1) Upon registration with the department, an Indian tribe, tribal unit or a subdivision, subsidiary or business enterprise wholly owned by a tribe not previously registered will be assigned an employer account number.

(2) An Indian tribe, tribal unit or a subdivision, subsidiary or business enterprise wholly owned by a tribe previously registered as part of a master account may be assigned a new account number.

[11.3.400.422 NMAC - N, 01-01-2003; A, 10-15-2014]

11.3.400.426 APPLICATION OF UNDERPAYMENTS: In the event an employing unit fails to submit payment in an amount sufficient to satisfy the total amount of outstanding debt for any current or past-due contributions, interest or penalty, the amount of the underpayment shall be applied in the following order: [~~first, to any contributions due pursuant to contribution schedule A and contributions schedules zero (0) through six (6) of NMSA 1978 Section 51-1-11; second, to any contributions due pursuant to contribution schedule B of NMSA 1978 Section 51-1-11; third, to any interest due, and fourth, to any penalties due~~] first, to any contributions and excess claims premiums due, second, to any interest due and third, to any penalties due.

[11.3.400.426 NMAC - N, 07-16-2007; A, 10-15-2014]

11.3.400.427 ADEQUATE RESERVE DETERMINATION: The department shall ensure that the fund sustains an adequate reserve.

A. An adequate reserve shall be determined to mean that the funds in the fund available for benefits equal the total amount of funds needed to pay between eighteen and twenty-four months of benefits at the average of the five highest years of benefits paid in the last twenty-five years.

B. For the purpose of sustaining an adequate reserve, the department shall determine a reserve factor to be used when calculating an employer's contribution rate based upon a formula that will set the reserve factor in proportion to the difference between the amount of funds available for benefits in the fund, as of the computation date, and the adequate reserve, within the following guidelines:

(1) 1.0000 if, as of the computation date, there is an adequate reserve;

(2) between 0.5000 and 0.9999 if, as of the computation

date, there is greater than an adequate reserve; and

(3) between 1.0001 and 4.0000 if, as of the computation date, there is less than an adequate reserve.

C. The New Mexico adequate reserve multiple (NMARM) is a measure of fund adequacy used in determining the reserve factor. The NMARM is equal to the reserve ratio divided by the average benefit cost rate. The reserve ratio is the trust fund balance, as of June 30, divided by calendar year total wages. The average benefit cost rate is the average of the state's five highest benefit cost rates, during the preceding twenty-five years. The benefit cost rate is calendar year benefit payments divided by the sum of total wages for the same period.

D. The formula for setting the reserve factor shall be determined as follows:

(1) If NMARM $\leq$ 0.5 then Reserve Factor = 4.

(2) If 0.5 < NMARM < 1.5 then Reserve Factor = 11/2 - 3×NMARM.

(3) If 1.5 $\leq$ NMARM $\leq$ 2 then Reserve Factor = 1.

(4) If 2 < NMARM < 3.150 then Reserve Factor = 43/23 – 10/23×NMARM.

(5) If NMARM $\geq$ 3.150 then Reserve Factor = 0.5.

[11.3.400.427 NMAC - N, 10-15-2014]

HISTORY OF 11.3.400 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives Under ESD 74-1, Unemployment Compensation Law of New Mexico and Rules and Regulations of the Commission, filed 10-1-74; Regulation 401, Records of Employing Units, amended and filed 5-04-90; Regulation 402, Identification of Employees, amended and filed 5-25-90; Regulation 403, Posting of Notices, amended and filed 5-25-90; Regulation 404, Tax Reports by Employing Units, amended and filed 5-25-90, Regulation 405, Quarterly Payment of Contributions, amended and filed 5-25-90; Regulation 406, Due Date for Payment of Contributions Notice of Delinquency; Interest and Penalties, amended and filed 5-25-90; Regulation 407, First Payment of Contributions for New Employers and Employers Electing Coverage, amended and filed 6-14-90; Regulation 408, Payment of Contributions for Uncompleted Calendar Quarters amended and filed 6-14-90; Regulation 409, Report to Determine Liability, amended and filed 6-14-90; Regulation 409A, Report of Change in Status, amended and filed 6-14-90; Regulation 410, Extension of Due Date for Filing Quarterly Reports or Payment of Contributions or Payments in Lieu of Contributions, amended and filed 6-14-90; Regulation 411, Interest on Unpaid Contributions or Payments in Lieu of Contributions, amended and filed 6-14-90; Regulation 412, Imposition of Penalties for Late Reports and Late Payment of Contributions or Payments in lieu of Contributions, amended and filed 8-17-90; Regulation 413, Procedure for Relief from Penalties, amended and filed 8-17-90; Regulation 414, Grounds for Relief from Penalties, amended and filed 8-17-90; Regulation 415, Experience Rating of Employers, amended and filed 9-20-94; Regulation 416, Business Transfers Defined; Effective Date, amended and filed 8-17-90; Regulation 417, Experience History Transfers, amended and filed 8-17-90; Regulation 418, Time for Correction of Erroneous Rate Determinations, amended and filed 10-9-90; Regulation 420, Employer Elections to Cover Multi-State Workers, amended and filed 10-9-90; Regulation 423, Partnerships, filed 10-9-90; Charging of Benefits Paid Due to Federal Disaster, filed 2-14-01.

History of Repealed Material: [RESERVED]

End of Adopted Rules Section

Other Material Related to Administrative Law

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

RESPONSE TO PUBLIC COMMENT ON PROPOSED RULEMAKING

The proposed changes to Parts 1, 4 and 5 of the Workers' Compensation Administration ("WCA") Rules were released for public comment on July 17, 2014. The public comment period was from July 17, 2014 through August 18, 2014. In addition to written comments, the WCA accepted oral comment at a public hearing on August 7, 2014.

The undersigned appreciates all of those who took the time to submit comments regarding the proposed amendments.

PART 1

Comments were received regarding the proposed changes to definitions within Part 1 of *party*, *bad faith*, and *unfair claims processing*. Comments were also received regarding the revisions to the section on confidentiality of WCA records.

Regarding the definition of *party*, some commentators indicated the proposed additions were too broad, that they have the effect of expanding the WCA's jurisdiction, and that they would increase litigation. This included specific opposition to the inclusion of the uninsured employers' fund and health care providers within the definition of *party*. Likewise, some commentators argued the proposed, catch-all enumeration is too ambiguous. Still other commentators indicated the changes are a welcome clarification.

Regarding the definition of *bad faith*, some commentators indicated the proposed changes conflict with statutory provisions. One commentator argued that intentional conduct was not necessary for a showing of *bad faith*. Another commentator indicated the change guts the current definition and that *bad faith* and *unfair claims processing* should be the same. Another commentator suggested that the WCA look to the Uniform Jury Instructions regarding punitive damages for guidance. Still other commentators indicated the changes to the definition of *bad faith* were welcome and a positive clarification - particularly in setting forth the difference between the offenses of *bad faith* and *unfair claims processing*.

Regarding the definition of unfair claims processing, some commentators indicated the proposed changes conflict with Court of Appeals precedent from Church's Fried Chicken et. al. v. Teresa Hansen. One commentator indicated the change guts the current definition and that *bad faith* and *unfair claims processing* should be the same. Another commentator described the proposed changes as a dilution and a cut to the rights of workers. Multiple commentators objected to the striking of enumerated offenses under the *unfair claims processing* definition. One commentator suggested alternative language of "any practice performed with such frequency as to indicate a general business practice which unreasonably delays or prolongs the payment of benefits at a rate not consistent with the Act." Still other commentators indicated the changes to the definition of *bad faith* were welcome and a positive clarification - particularly in setting forth the difference between the offenses of *bad faith* and *unfair claims processing*.

Regarding the revisions to the section of Part 1 dealing with production of WCA records, a comment was received that only workers, employers, or insurers should have access to WCA records without a court order. The same commentator requested further explanation as to the meaning of the changes.

Response:

Part 1 of the WCA Rules sets forth general definitions for terms that appear in all sections of the WCA Rules - i.e. Parts 1 through 13. Most commentators relied on their experience as attorneys representing either injured workers or employers/insurers only within the context of Part 4 of the WCA Rules. However, the definitions in Part 1 are meant to apply in a variety of contexts beyond the prototypical "worker v. employer/insurer" case caption.

Party

The changes to the definition of *party* are intended to simply reflect current reality and not as a substantive change or expansion of WCA jurisdiction. For example, the uninsured employer fund has appeared as a party litigant in workers' compensation cases before the WCA Court since the fund's inception in 2003. The WCA Rules at Part 12 already provide that the "fund, in conjunction with the independent adjusting company, if any, shall pay or oppose claims on their merit, and shall be treated for purposes of mediation and adjudication of disputes as a party with all rights and responsibilities applicable under law." Paragraph (1) of Subsection A of 11.4.12.9 NMAC. Part 1 of the WCA Rules, including the definition of *party*, has not been revised since before the fund's inception.

Health care providers are included within the revised definition of *party* to simply reflect that they do in fact appear as party litigants in billing disputes (i.e. "HCP v. Insurer" disputes, or vice versa) and when seeking approval from the WCA for qualification as an out-of-state provider. Their inclusion within the definition does not broaden the jurisdiction of the WCA beyond what already exists. In light of this concern, however, the proposed Paragraph (4) of Subsection P of 11.4.1.7 NMAC will be amended to "a health care provider named in a billing dispute or seeking qualification as an out-of-state provider."

The catch-all enumeration in the definition of party is intended to cover miscellaneous actions and hearings to enforce the provisions of the Workers' Compensation Act. Potential parties can include individuals and businesses that have violated any provision of the workers' compensation statutes, including, but not limited to, failing to secure workers' compensation coverage, failing to conduct safety inspections as required, failing to submit required reports, failing to abide a lawful subpoena issued by the WCA, failing to abide by the terms of a self-insurance certification or owner controlled insurance plan, fraudulent activity affecting workers' compensation, etc. In light of the concerns expressed, however, the proposed Paragraph (5) of Subsection P of 11.4.1.7 NMAC will be amended to "any other person or entity named in an administrative enforcement proceeding."

Unless otherwise noted above, the definition of *party* will be amended as originally proposed.

Bad faith and ***Unfair Claims Processing***

The director is charged by statute with defining *bad faith* and *unfair claims processing*. See NMSA 1978, Section 52-1-28.1(E) and Section 52-3-45.1(E). The current definitions are convoluted and conflicting. The current definition of *unfair claims processing* does not in fact define the term, but rather only provides enumerated examples. The purpose of the revisions was to simplify the definitions, clarify the type of conduct prohibited under each term, and to set forth their relationship to

each other. Under the proposed definitions, *bad faith* and *unfair claims processing* are separate offenses. *Bad faith* is proposed to be the more serious offense to address more serious misconduct. The terms are party neutral - i.e. a worker can be found in violation of either, as can an employer or an insurance company.

The proposed definition of *bad faith* largely borrows the definition of that term already found in statute at Section 52-1-54(I). Upon further consideration, and in light of the comment arguing that the word, "intentional," is unnecessary in the definition, the definition will be amended to: "*Bad faith* means conduct in the handling of a claim by any person that amounts to fraud, malice, oppression or willful, wanton or reckless disregard of the rights of any party." This final definition matches the statutory definition at Section 52-1-54(I) even more closely.

The proposed definition of *unfair claims processing* aims to set a clear, base-line threshold and not rely solely on enumerated examples. The enumerations stricken in the proposed rule do not signify that the prohibited conduct in those enumerations is now acceptable, but only that the enumerations are not necessary because of the base-line threshold set forth or because they are duplicative. Based on public comment received, the current Paragraphs (5) and (6) of Subsection Y of 11.4.1.7 NMAC will remain as enumerated examples of *unfair claims processing*. Likewise, based on public comment received, the proposed addition at Paragraph (8) of Subsection W of 11.4.1.7 NMAC will be stricken from the final rule. This enumeration, regarding the unreasonable refusal to allow communication between an employer and an HCP, drew the most criticism in public comment. It is left out of the final rule to give the WCA further opportunity to consider the matter. The issue of communication between payors and providers is addressed further in response to the comments on Part 4.

Unless otherwise noted above, the definitions of *bad faith* and *unfair claims processing* will be amended as originally proposed.

Confidentiality

The amendments to 11.4.1.8 NMAC - "Confidentiality" is aimed at explaining the process for production of WCA records. It fleshes out the statutory provisions of NMSA 1978, Section 52-5-21. The bulk of the changes were to format and placement - not substance. For example, most of the added material in the proposed Subsection A of 11.4.1.8 NMAC was taken from the stricken definition of records in the current Subsection BB of 11.4.1.7 NMAC.

There are two types of records that the WCA maintains - public records and confidential records. Anyone can access public records as long as they follow the process outlined in the proposed rule. Access to confidential records, however, is restricted by statute. Individuals seeking access to confidential records must follow the process outlined in the proposed rule, but also must fall within one of the categories the statute creates for access to such records.

The proposed changes to the "Confidentiality" rules in Part 1 will be promulgated as originally proposed.

PART 4

Part 4 of the WCA Rules deals with the claims resolution process. A comment was received regarding the proposed revision to Subsection E of 11.4.4.9 NMAC dealing with incomplete filings with the clerk. The commentator indicated approval for the revision generally, but also questioned the process for notifying a party of its incomplete filing.

A comment was received regarding the amendment at Paragraph (4) Subsection B of 11.4.4.10 NMAC dealing with mandatory production of documents at mediation. The commentator indicated direct delivery of the documents to the mediator would be a better avenue than delivery through the clerk of the court.

A comment was received regarding the proposed striking of "calendar days" throughout the rule. The commentator indicated that *pro se* claimants may be negatively impacted by this change.

A comment was received supporting the addition at Paragraph (1) of Subsection F of 11.4.4.11 NMAC regarding attaching a copy of the notice of change of health care provider to a filed objection.

Multiple comments were received opposing the proposed amendment at Paragraph (4) of Subsection C of 11.4.4.12 NMAC dealing with resolution of disputes regarding judge assignments by the WCA Director. One commentator suggested assigning an "independent judge" to hear such disputes and questioned the Director's role in hearing them. One commentator indicated approval of the proposal, but suggested the Director hold these hearings personally rather than delegate to a designee.

Comments were received regarding the proposed addition at 11.4.4.14NMAC - "Sanctions." One commentator indicated that there should be an enumerated sanction allowing a workers' compensation judge to enter default judgment against an employer/insurer. Another commentator indicated that the rule gave too much discretion to judges and that the legal standards or thresholds for imposing sanctions were not clear.

Comments were received regarding the proposed addition at Subparagraph (h) of Paragraph (1) of Subsection A of 11.4.4.12 NMAC - allowing a party to file an application to workers' compensation judge seeking "approval of limited discovery where no complaint is pending before the agency, including, but not limited to, approval of a communication to a treating health care provider" (new, proposed language underlined). Comments fell on both sides. Some commentators indicated the proposed addition was needed and appreciated. Some commentators indicated the addition oversteps the WCA's rulemaking authority and contradicted case law. One commentator suggested the WCA narrow, or clarify, the proposed addition by explicitly excluding *ex parte* communications. Another commentator suggested parties be required to attach a copy of a proposed, written communication for the judge's review along with the filed application.

Response:

The proposed revision to Subsection E of 11.4.4.9 NMAC codifies and clarifies the WCA's current practice for dealing with incomplete filings. The clerk's office notifies the filing party of the defect and allows reasonable time - 15 days in the proposed rule - to cure the problem so that the pleading can be processed. If the party does not cure the problem within that time period, the clerk's office closes the file by filing a notice of administrative closure. The method for contacting the filing party by the clerk's office will depend on the circumstances - i.e. if the filing party does not include a mailing address, the clerk's office will not be able to notify the party by mail.

The proposed addition at Paragraph (4) of Subsection B of 11.4.4.10 NMAC clarifies how parties should deliver mediation exhibits to the WCA prior to a mediation conference. It also clarifies that the WCA will not store mediation exhibits beyond the mediation phase of the claim. The suggestion of producing mediation exhibits directly to an assigned mediator is appreciated and is also taken as helpful feedback on the WCA's document

management shortcomings. However, the assignment of mediators to cases changes frequently and sometimes at the last minute. In such situations, exhibits produced to the originally assigned mediator may not make it to the newly assigned mediator. Nonetheless, there is no prohibition on forwarding additional copies directly to the mediator(s) should a party desire added peace of mind.

The striking of "calendar days" throughout Rule 4 is intended to bring consistency to the computation of time within the claims resolution context. The proposed addition at Subsection B of 11.4.4.9 NMAC sets forth that the WCA will follow the rules of civil procedure for the district courts when computing time periods and deadlines - unless otherwise noted. The proposed addition is also consistent with computation of time set forth in NMSA 1978, Section 12-2A-7.

The proposed addition at Paragraph 4 of Subsection C of 11.4.4.12 NMAC clarifies the avenue for resolving a dispute about the assignment, re-assignment, or disqualification of workers' compensation judges. The WCA has used various methods to handle these types of disputes over the years—each with its drawbacks - and all without apparently having a written, codified rule. The proposed rule clarifies the process, centralizes it, and avoids putting judges or parties in untenable or uncomfortable situations when furthering arguments. The proposed approach is the current, default approach, and it is favored by the judges themselves. Further, the WCA is not part of the judiciary. Thus, judicial rules or case law discussing how the judiciary handles judge assignment issues are instructive, but not binding on the WCA. Decisions of the WCA Director are generally appealable to district court.

The proposed addition of 11.4.4.14 NMAC - "Sanction" is both a re-format of the rules and a clarification of the judges' authority to control the legal proceedings before them and to punish those who engage in misconduct before the court. The new section largely borrows language stricken in the current 11.4.4.13 NMAC. The rule for sanctionable conduct was revised to provide a base-line threshold, as well as some enumerated examples. This list is not exhaustive. Workers' compensation judges should have wide latitude to maintain order and punish bad behavior occurring in the legal proceedings before them. This authority is provided by statute, NMSA 1978, Section 52-5-6(B), (C), and (D) (2001), and was specifically recognized by the Court of Appeals in Chavez v. WCA, 2012-NMCA-060. As for the enumerated list of possible sanctions, they are not new or somehow a broadening of the judges' current authority. This list merely codifies the sanctions already available and used by workers' compensation judges.

The proposed addition at Subparagraph (h) of Paragraph (1) of Subsection A of 11.4.4.12 NMAC attempts to resolve a problem afflicting the workers' compensation system. The lack of communication between injured workers, employers/insurers, and health care providers is one of the leading causes of delay, litigation, and unnecessary expense in the workers' compensation system. It negatively impacts the statutory mandate of assuring the quick and efficient delivery of indemnity and medical benefits to injured and disabled workers at a reasonable cost to employers. It also leads to trivial disputes and unnecessary adjudication before the WCA and it increases costs to all involved. Providing an avenue for court-sanctioned and monitored communication strikes a balance between an injured worker's privacy interests, read into statute by the Court of Appeals in Church's Fried Chicken et. al. v. Teresa Hansen, and the parties uniform interest in getting medical questions addressed quickly so that care is not interrupted, costs (i.e. attorney fees, deposition fees, etc.) are minimized, and the WCA is not forced to deal with disputes that the parties should have been able to work out themselves.

The proposed language in Subparagraph (h) of Paragraph (1) of Subsection A of 11.4.4.12 NMAC does not conflict with Church's or its progeny. Case law does not provide for an absolute doctor-patient privilege. Workers' compensation judges frequently authorize depositions of treating health care providers. The WCA has long approved of a form letter to health care providers with standardized questions which either party can transmit without the other's consent. The proposed rule merely allows for greater flexibility in fashioning an intermediate level of communication that will best address the needs of the parties to a particular claim. Furthermore, the communications allowed under the proposed rule will not be *ex parte* (i.e. outside the presence of the injured worker or representative) but should be tailored by the judge so that the medical question can be addressed in the most reasonable and timely manner possible. In reviewing a proposed communication under this rule, judges may of necessity need to consider many factors, including relevance, urgency, the form and length of proposed communications (telephone v. meeting v. correspondence, etc.) and whether the proposed communication will likely bring resolution to a dispute.

Upon further consideration and in light of comments made, the proposed rule will be amended to: "(h) approval of limited discovery where no complaint is pending before the agency, including, but not limited to, approval of a communication to a treating health care provider when the parties cannot otherwise agree on the form or content." This is done to stress to parties the prerequisite of attempting in good faith to resolve a matter before bringing it to a workers' compensation judge for consideration.

Unless otherwise noted above, the proposed amendments to Part 4 of the WCA Rules will be promulgated as originally proposed.

PART 5

Minimal comments were received regarding the proposed changes to Part 5 of the WCA Rules. One commentator questioned the Director's authority to issue penalties under this section and questioned the fact scenarios anticipated for hearings under this section. Other commentators indicated the changes to Part 5 were a good clarification and streamline of the processing of claims. One commentator suggested keeping the language stricken under the current Paragraphs (1) through (4) of Subsection (C) of 11.4.5.9 NMAC.

Response:

The purpose of the revisions to Part 5 is to clarify the process of enforcement proceedings and administrative investigations. The statutory authority for this section, including the issuance of penalties by the Director, is clear and is summarized at 11.4.5.3 NMAC. The deletion of the current Paragraphs (1) through (4) of Subsection (C) of 11.4.5.9 NMAC was done because the language is duplicative - i.e. all four enumerations essentially say the same thing.

The amendments to Part 5 will be promulgated as originally proposed.

These rules will be adopted pursuant to NMSA 1978, Section 52-5-4.

Publication in the New Mexico Register

In addition to the proposed amendments, Parts 1, 4, and 5 are not currently in the numbered and styled format required by the New Mexico Administrative Code. In order to comply with directives from the New Mexico State Records and Archives regarding formatting of the Administrative Code, the final rules will be filed with

the New Mexico Register as repealed and replaced. The final rules contain the proposed published amendments opened for public comment and revised following public comment as discussed above.

The public record of this rulemaking shall incorporate this Response to Public Comment and the formal record of the rulemaking proceedings shall close upon execution of this document.

Electronically signed 9/15/14

DARIN A. CHILDERS, Director
N.M. Workers' Compensation Administration
September 15, 2014

NEW MEXICO COMMISSION OF PUBLIC RECORDS

ADMINISTRATIVE LAW DIVISION

NEW MEXICO REGISTER: NOTICE OF FEE INCREASE

The Administrative Law Division, on behalf of the State Records Administrator, hereby gives notice that, effective today, October 15, 2014 and pursuant to amendments to 1.13.2.19 and 1.24.15.12 NMAC, the cost of publishing in the New Mexico Register increases from **$2.00 per columnar inch** to **$2.50 per columnar inch**.

Copies of the amended rules pertaining to publication cost increase are available at the Administrative Law Division, State Records Center and Archives located at 1205 Camino Carlos Rey, Santa Fe, NM 87507 and on the Commission of Public Records website at: www.nmcpr.state.nm.us/index.htm.

End of Other Related Material Section

Submittal Deadlines and Publication Dates
2014

Volume XXV	Submittal Deadline	Publication Date
Issue Number 20	October 16	October 30
Issue Number 21	October 31	November 13
Issue Number 22	November 14	November 26
Issue Number 23	December 1	December 15
Issue Number 24	December 16	December 30

New Mexico Register
Submittal Deadlines and Publication Dates
Volume XXVI, Issues 1-24
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Volume XXVI	Submittal Deadline	Publication Date
Issue Number 1	January 2	January 15
Issue Number 2	January 16	January 30
Issue Number 3	February 2	February 13
Issue Number 4	February 16	February 27
Issue Number 5	March 2	March 16
Issue Number 6	March 17	March 31
Issue Number 7	April 1	April 16
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Issue Number 9	May 1	May 14
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Issue Number 20	October 16	October 29
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Issue Number 24	December 16	December 30

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