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Notices of Rulemaking and Proposed Rules

ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT
STATE PARKS DIVISION

NOTICE OF PROPOSED RULEMAKING

The State of New Mexico, Energy, Minerals and Natural Resources Department (EMNRD), State Parks Division hereby gives notice of the following proposed rulemaking. EMNRD proposes to amend its rule, 18.17.2 NMAC, Boating Operation and Safety.

Purpose of Amendment. EMNRD proposes the amendments to remove the flotation assist device definition; amend the definition of personal flotation device to include language consistent with US Coast Guard regulations; amend the definition of power driven vessel to include "at the time of operation"; to codify the placement of a validation sticker for motorboat registration; to amend requirements for the carry of throwable flotation devices; to amend requirements for personal flotation devices consistent with US Coast Guard regulations; to amend fire extinguisher size and type consistent with US Coast Guard regulations; to amend light requirements consistent with US Coast Guard regulations; to amend other equipment required on paddle craft and inflatable vessels; to amend provisions regarding prohibited operations for clarity; to amend language for tampering, mooring, or otherwise anchoring to buoys and other water marking systems; to add emergency cutoff switch requirements; to amend accident report provisions for clarity; to amend traffic control provisions for clarity; to amend restricted operations on state waters; and add a provision to allow State Parks Division officers, New Mexico State Police and county sheriffs to terminate voyage for unsafe operation of vessels.

EMNRD proposes to remove the definition of floatation assist device in 18.17.2.7 NMAC because there is no requirement or recommendation in current statute or rules for the application of such device. Additionally, no data exists in New Mexico that support the requirement of a floatation assist device for recreational water users.

EMNRD proposes to amend the definition of personal flotation device (PFD) to include language consistent with US Coast Guard regulation 33 CFR 175.15. Pursuant to the findings of a routine program audit the US Coast Guard conducted, their recommendation is to amend State Parks Division rules to remove PFD type code terminology throughout State Parks Division Rules and replace it with language approved by the US Coast Guard.

EMNRD proposes to amend the definition of power-driven vessel to include the operation of vessels whose main propulsion is not by mechanical means to be considered power driven at the time it is propelled by machinery.

EMNRD proposes to add terminology to 18.17.2.8(B) NMAC requiring the registration validation sicker be affixed within six inches to the right of the registration number on the port side of the vessel pursuant to the results and recommendation of the US Coast Guard program audit and consistent with 33 CFR 174.15.

In 18.17.2.9(A) NMAC, EMNRD proposes to amend the requirements to carry throwable flotation devices on paddle craft or inflatable vessels for consistency and clarification.

EMNRD proposes to amend the provisions regarding the wearing of a PFD consistent with 33 CFR 175.15, which eliminates the "type code" terminology and adds language pertaining to the use of PFDs consistent with the PFD label.

In 18.17.2.9(B) NMAC, EMNRD proposes to amend the provisions pertaining to size and type of fire extinguishers, so they are consistent with 33 CFR 175.320.

In 18.17.2.9(F) NMAC, EMNRD proposes to amend the light requirements as a result and requirement of the US Coast Guard program audit to include language that pertains to vessels under sail and paddle craft, consistent with 33 CFR 83.20.

In 18.17.2.9(G) NMAC, EMNRD proposes to amend the provision pertaining to equipment not required on paddle craft and inflatable vessels for clarification.

In 18.17.2.11 NMAC, EMNRD proposes to amend the provisions pertaining to prohibited operation for clarification. For general safety, operators will not be allowed to authorize persons to participate in unsafe behavior while the vessel is underway, and passengers will not be allowed to participate in unsafe behavior while the vessel is underway independent of the operator's knowledge or consent.

EMNRD proposes to amend the provisions pertaining to the restriction and prohibition of activities involving tampering with government placed marking and safety buoys and the safe navigation of vessels in marked channels.

In 18.17.2.11(J) NMAC, EMNRD proposes to add a provision pertaining to the requirement of the use of an emergency cutoff switch while the vessel is above wake speed or on plane pursuant to 46 USC 4312 with certain exceptions.

In 18.17.2.12 NMAC, EMNRD proposes to amend the language pertaining to the use of an accident report, to remove the requirement for the use of a US Coast Guard form.

In 18.17.2.15(E) NMAC, EMNRD proposes to amend the provision pertaining to traffic control while on the water for clarification and safety of operation.

In 18.17.2.16 NMAC, EMNRD proposes to amend the provisions pertaining to restricted operations on state waters for clarification and consistency.

EMNRD proposes to add a new section, 18.17.2.18 NMAC, that will allow a State Parks Division law enforcement officer, NM State Police officer, and county sheriff to terminate or prevent the voyage of a vessel in the event the vessel/operator is deemed unsafe contrary to certain provisions of 18.17.2 NMAC or in the interest of public safety.

Legal Authority. EMNRD proposes this rule amendment under the authority of NMSA 1978, Section 66-12-18.

The full text of the proposed rule amendment is available from Wendy Mason at 505-819-1785 or wendy.mason@emnrd.nm.gov or can be viewed on the EMNRD, State Parks Division's website at https://www.emnrd.nm.gov/spd/public-meetings/ or at the State Parks Division's office in Santa Fe.

Public Hearing and Comment. EMNRD will hold a public hearing on the proposed rule amendments at 9:00 a.m. on Wednesday, January 31, 2023, at the New Mexico Law Enforcement Academy Auditorium, 4491 Cerillos Rd, Santa Fe, NM.

Those wishing to comment on the proposed rule amendment may make oral comments or submit information at the hearing or may submit written comments by January 31, 2023, by 9:00 a.m. by mail or email. Please mail written comments to Wendy Mason, EMNRD, State Parks Division, 1220 South Saint Francis Drive, Santa Fe, New Mexico 87505 or submit comments by email to wendy.mason@emnrd.nm.gov.

Technical Information that served as a basis for the proposed rule amendments includes:

Copies of the technical information can be obtained from Manuel Overby at 505-570-7501 or manuel.overby1@emnrd.nm.gov or can be viewed on the EMNRD, State Parks Division's website at https://www.emnrd.nm.gov/spd/public-meetings/.

46 USC 4312. (b), Engine cut-off switches; use requirement
33 CFR 83.20, Navigation and navigable waters, inland navigation, lights and shapes
33 CFR 83.25, Sailing vessels underway and vessels under oar
33 CFR 174.15(a), State numbering and casualty reporting systems; validation stickers
33 CFR 175.15, Personal floatation devices required
33 CFR 175.17, Personal floatation devices required, exemptions
33 CFR 175.21, Condition, size and fit; approval marking
33 CFR 175.320, Fire extinguishing equipment required
33 CFR 70.01 & 70.05, Interference with aids to navigation/Collision with or damage to aids to navigation
33 CFR 83.03, General definitions, power-driven vessel, sailing vessel
36 CFR 3.8, What vessel operations are prohibited
2022 NM DR State Letter, USCG Compliance Review Results, July 28, 2022

If you are an individual with a disability who needs a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing, please contact Wendy Mason at (505) 819-1785 or through the New Mexico Relay Network at 1-800-659-1779 two weeks prior to the hearing. Public documents can be provided in various accessible formats. Please contact Wendy Mason at (505) 819-1785 or by email at wendy.mason@emnrd.nm.gov, if a summary or other type of accessible format is needed.

INFORMATION TECHNOLOGY, DEPARTMENT OF

NOTICE OF PROPOSED RULEMAKING

NOTICE IS HEREBY GIVEN that the Department of Information Technology ("DoIT") and the Connect New Mexico Council ("Council"), pursuant Paragraphs A and B of Section 9-27-6 NMSA 1978 and Paragraph C of Section 63-9K-4 NMSA 1978, proposes to adopt a new rule, 1.12.21 NMAC, GRANT PROGRAM RULES

PURPOSE OF THE PROPOSED NEW RULE IS: The purpose of these rules is to establish standards and practices for the development, challenge, application, award and administration of grant programs funded with appropriations to DoIT, the Council and attached agencies, bodies, offices and boards.

STATUTORY AUTHORITY: Paragraphs A and B of Section 9-27-6 NMSA 1978; Paragraph C of Section 63-9K-4 NMSA 1978.

Copies of the Notice of Proposed Rulemaking and proposed rule are available by electronic download from the DoIT website https://www.doit.nm.gov/rulemaking/ or the New Mexico Sunshine Portal.

DoIT will hold a public video/telephonic hearing on the proposed rule on January 30, 2023, at 10:00 a.m.

Join via Video: https://us06web.zoom.us/j/3118026550?pwd=Q3BZR3ptSyt4eHNqeTlDUDdzNnZjZz09
Join via telephone: 1-346 248 7799
Meeting ID: 311 802 6550 Passcode: 680732

DoIT and the Council designate Bryan E. Brock to act as the hearing officer for this rulemaking. Oral comments will be accepted at the video/telephonic hearing from

members of the public and any interested parties.

Written comments and proposals will be accepted through 4:00 pm on January 30, 2023. Responses to written comments or oral comments will be accepted through 4:00 pm on February 10, 2023. Comments may be submitted online at https://www.doit.nm.gov/rulemaking/ or may be filed by sending original copies to:

Melissa Gutierrez, Law Clerk,
Department of Information Technology
715 Alta Vista St., Santa Fe, NM 87505

Written comments suggesting changes or alternatives to the proposed rule should provide justification for each suggested change or alternative and include all suggested rule language necessary to effectuate the suggested change or alternative. Suggested changes to the proposed rule should be provided in a redline format showing proposed deletions and additions.

Docket No.: 23-0001
IN THE MATTER OF ADOPTION OF GRANT PROGRAM RULES

Only signed statements, proposals, or comments will be accepted. Scanned or electronic signatures conforming to federal and state court requirements will be accepted with the understanding that if there is any dispute regarding a signature, DoIT reserves the right to require that original signatures be provided to verify the electronic signature. All filings must be received between the hours of 8:00 a.m. and 4:00 p.m. Monday through Friday except on state holidays. Any filings after 4:00 will be filed to the docket the next business day.

SPECIAL NEEDS: Any person with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or other auxiliary aid or service to attend or participate in the hearing should contact Melissa Gutierrez at 505-819-7360 ten (10) business days prior to the hearing.

The Council and DoIT will consider all oral comments and will review all timely submitted written comments and responses.

ISSUED this 27th day of December 2023
/S/Peter Mantos

STATE TREASURER'S OFFICE

NOTICE OF PUBLIC HEARING

Public Rulemaking Hearing
The New Mexico Work and Save Board will hold a public hearing on proposed rulemaking for the New Mexico Work and Save Programs. The hearing will be held on Monday, January 30, 2023, beginning at 9:00 a.m. (MDT) at the New Mexico State Treasurer's Office, 2055 S. Pacheco St, Ste. 100, Santa Fe, N.M. 87505, and online via a Zoom webinar link. Any interested member of the public may attend the hearing and submit data, views, or comments either orally or in writing.

Purpose of Rules Hearing
The purpose of the public hearing is to consider the proposed new rules set forth pursuant to the New Mexico Work and Save Act regarding the design, implementation, and operation of the Work and Save Programs, specifically the General Provisions and the Retirement Plan Marketplace. The hearing will be used to receive public comment on the proposed rules. Attendees who wish to provide public comment on record will be given every reasonable opportunity to offer comment.

Public Comment
The Board will begin receiving public comment on the proposed new rules beginning Wednesday, December 28, 2022. Written comments must be received no later than 4:00 p.m. (MDT), Friday, January 27, 2023, and can be sent via email to Maria.Spray@sto.nm.gov, or by post to New Mexico Work and Save Board, 2055 S. Pacheco St., Ste. 100, Santa Fe, N.M. 87505. Written comment will not be received during the hearing. All written comments will be posted on the Work and Save Board website within three days of receipt.

Statutory Authority
The legal authority authorizing the proposed rulemaking is the New Mexico Work and Save Act, Sections 58- 33-1 through 58-33-12 NMSA 1978, (2020) as amended.

Summary of Proposed New Rules
These rules apply to the New Mexico Work and Save Board and its employees and contractors, including the Marketplace financial service providers who offer, or seek to offer, plans on the New Mexico Retirement Plan Marketplace; and employers that purchase retirement plans from the Marketplace. The rules will provide information on the following:

12.13.1 NMAC	General Provisions
12.13.30 NMAC	Retirement Plan Marketplace

12.13.1 NMAC - GENERAL PROVISIONS
Part 1 will provide the general provisions and definitions that apply to all of Title 12, Chapter 13 and to all persons affected or regulated by Title 12, Chapter 13

12.13.30 NMAC - RETIREMENT PLAN MARKETPLACE
Part 30 will provide guidance for financial service providers regarding minimum requirements, procedures for applications, and fees charged for participation on the Retirement Plan Marketplace.

Purpose of Proposed Rules:
The rules are proposed to provide guidance regarding the operation of, and oversight for, the New Mexico Work and Save Programs. The rules will provide specific guidance to the Board and its employees, and to employers and contractors doing

business in New Mexico in the purchase of retirement plans from the Marketplace.

Copies of Rules Full Text: Copies of the full text of the proposed New Mexico Work and Save Programs rules regarding the Retirement Plan Marketplace Rules, Definitions, and General Provisions may be found here: https://nmsto.gov/special-programs/work-and-save/ under the Rules tab. Requests for electronic or printed copies may be directed to Maria Spray at Maria.Spray@sto.nm.us.

Comments on Proposed Rules: Please send comments to Maria Spray at Maria.Spray@sto.nm.gov no later than 4:00 p.m., Friday, January 27, 2023.

Public Hearing Information: The public hearing will be held on Monday, January 30, 2023, at 9:00 a.m. Attendance in person will be at the New Mexico State Treasurer's Office, 2055 S. Pacheco St., Ste. 100, Santa Fe, N.M. 87505. Attendance via Zoom will be available by request made to Maria Spray at Maria.Spray@sto.nm.gov or 505-205-3567.

Individuals with Disabilities Individuals with disabilities who need any form of auxiliary aid to attend and/or participate in the public hearing are asked to contact Maria Spray at Maria.Spray@sto.nm.gov or call (505) 205-3567.

TRANSPORTATION, DEPARTMENT OF

NOTICE OF PROPOSED RULEMAKING

The New Mexico Department of Transportation (NMDOT) is proposing to repeal and replace rule 18.20.11 NMAC, Ignition Interlock Program Rule.

Approval of the initial rulemaking action for the proposed repeal and replacement of rule 18.20.11 NMAC was granted to NMDOT by the New Mexico State Transportation Commission on March 24, 2022, pursuant to Sections 9-1-5, 67-3-8 and 67-3-11, NMSA 1978. The legal authority authorizing this rulemaking is Sections 67-3-8 and Sections 66-5-35, 66-5-501 et seq., 66-7-506, 66-8-102 and 66-8-102.3NMSA 1978.

Summary of Full Text: The NMDOT is statutorily responsible for oversight and regulation of the use of ignition interlock devices, as well as oversight and regulation of ignition interlock device manufacturers, service center operators, installers, and service technicians in New Mexico, pursuant to NMSA 1978 §§ 66-5-35 and 66-8-102. The proposed rule replaces the outdated existing rule, thereby aligning the regulatory framework with currently available technology and practices regarding ignition interlock devices. The proposed rule includes rules regulating the licensing of ignition interlock device manufacturers; the licensing of ignition interlock device service centers; the certification of installers and service technicians; the training of certain employees of ignition interlock device service centers, including installers and service technicians; the use, maintenance, and reporting requirements for ignition interlock devices; and the availability of and criteria for assisting indigent drivers required to use an ignition interlock device.

Purpose: The purpose for this proposed repeal and replacement of rule 18.20.11 NMAC is to make appropriate updates since the ignition interlock program rule has not been updated since 2003. In the intervening years, major changes in technologies and program delivery have occurred; as a consequence, certain modifications to the rule are required at this time.

Full Text of the Proposed Rule: A copy of the full text of the proposed replacement rule 18.20.11 NMAC may be found on the NMDOT website at the following Internet link, under the *Public Notices* tab: https://dot.state.nm.us/content/nmdot/en/public-notices.html. To obtain a printed copy of the proposed replacement rule, contact Leann Adams at: Telephone (505) 629-2948 or Email: Leann.Adams@dot.nm.gov. A reasonable fee may be charged for printed copies.

Rulemaking Hearing: NMDOT will hold one statewide public hearing for the purpose of receiving oral and written public comment from interested parties on the proposed replacement rule, 18.20.11 NMAC. The hearing is scheduled on **Friday, January 27, 2023, from 1:00 PM to 3:00 PM** at New Mexico Department of Transportation General Office, Training rooms #1 and #2, 1120 Cerrillos Rd., Santa Fe, New Mexico 87504.

Written Comments: To submit written comments on or before date of hearing, please send to: Leann Adams, New Mexico Department of Transportation, P.O. Box 1149, Santa Fe, New Mexico 87504, at Telephone: (505) 629-2948 or Email: Leann.Adams@dot.nm.gov. Written comments will be accepted from the date this notice is published in the New Mexico Register, December 27, 2022, until the close of the hearing scheduled in this rulemaking. If you plan to submit written comments, argument or data, please make sure any documentation contains your name, phone number and email address. If submitting written comments by email, please indicate the rule number in the subject line. Oral comments will only be accepted at the public hearing, and may be subject to time limitations. After the close of the final hearing scheduled in this rulemaking, the rulemaking record will be closed and no other comments will be accepted. All written comments will be posted on the department's website within three days of receipt.

Accommodations: Any individual with a disability who is in need of an auxiliary aid or service to attend

or participate in the hearing, or who needs copies of the proposed rule revisions in an accessible form may contact Leann Adams at Telephone: (505) 629-2948, or Email: Leann.Adams@dot.nm.gov at least ten days before the hearing.

End of Notices of Rulemaking and Proposed Rules

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Adopted Rules

Effective Date and Validity of Rule Filings

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

HEALTH, DEPARTMENT OF

The New Mexico Department of Health has approved the repeal of its rule 7.2.2 NMAC - Vital Records and Statistics (filed 10/17/2019) and replaced it with 7.2.2 NMAC - Vital Records and Statistics adopted on 12/14/2022 and effective 12/27/2022.

HEALTH, DEPARTMENT OF

TITLE 7 HEALTH
CHAPTER 2 VITAL STATISTICS
PART 2 VITAL RECORDS AND STATISTICS

7.2.2.1 ISSUING AGENCY: Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics.
[7.2.2.1 NMAC - Rp, 7.2.2.1 NMAC, 12/27/2022]

7.2.2.2 SCOPE: These regulations govern the creation and maintenance of a system of vital records and health statistics in New Mexico and insure the integrity of all vital records and health statistics issued or maintained by the department of health.
[7.2.2.2 NMAC - Rp, 7.2.2.2 NMAC, 12/27/2022]

7.2.2.3 STATUTORY AUTHORITY: The regulations set forth herein are promulgated by the secretary of the department of health by the authority of Subsection F of Section 9-7-6 NMSA 1978 and implement the Vital Statistics Act, Sections 24-14-1 to 24-14-31 NMSA 1978, as amended. These regulations also implement certain sections of the Uniform Parentage Act, Section 40-11-1 et seq., NMSA 1978 at Sections 40-11-5 and 40-11-6 NMSA 1978. These regulations also implement reporting for medical aid in dying, Section 24-1-43 NMSA 1978.
[7.2.2.3 NMAC - Rp, 7.2.2.3 NMAC, 12/27/2022]

7.2.2.4 DURATION: Permanent.
[7.2.2.4 NMAC - Rp, 7.2.2.1 NMAC, 12/27/2022]

7.2.2.5 EFFECTIVE DATE: 12/27/2022, unless a later date is cited at the end of a section.
[7.2.2.5 NMAC - Rp, 7.2.2.5 NMAC, 12/27/2022]

7.2.2.6 OBJECTIVE: These regulations are promulgated pursuant to statute for the purpose of installing, maintaining and operating a system of vital statistics throughout this state.
[7.2.2.6 NMAC - Rp, 7.2.2.6 NMAC, 12/27/2022]

7.2.2.7 DEFINITIONS: As used in these regulations.

A. Definitions beginning with "A": "Act" means the Vital Statistics Act, Sections 24-14-1 to 24-14-31, NMSA 1978 as amended.

B. Definitions beginning with "B": "Bureau" means the vital records and health statistics bureau, epidemiology and response division) within the department of health, which was formerly and in the statute referred to as the vital statistics bureau. Vital Statistics Act Section 24-14-1 et seq., NMSA 1978.

C. Definitions beginning with "C":

(1) "Certificate of still birth" means a certificate created by the BVRHS at the request of a parent named on a report of spontaneous fetal death which captures data from a report of a spontaneous fetal death reported in accordance with New Mexico law. The certificate is intended to memorialize a stillbirth event, but cannot be used as proof of a live birth, for identification or other legal purposes.

(2) "Certifier", for purposes of death records means a person authorized to certify cause of death pursuant to the laws of New Mexico.

(3) "Court ordered custodian" means the New Mexico children youth and families department when that department has legal custody of the child pursuant to a court order issued by a court of competent jurisdiction in the state of New Mexico.

D Definitions beginning with "D":

(1) "Dead body" means a human body or such parts thereof other than skeletal remains which cannot be classified as artifacts; dead within the meaning of Section 12-2-4 NMSA 1978.

(2) "Department" means the department of health.

E. Definitions beginning with "E": [RESERVED]

F. Definitions beginning with "F":

(1) "Fetal death" means death prior to complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any evidence of life such as beating of the heart, pulsation of the umbilical cord, or

definite movement of voluntary muscles.

(a) "Induced termination of pregnancy" means the purposeful interruption of pregnancy with the intention other than to produce a live-born infant or to remove a dead fetus, and which does not result in a live birth; induced abortion.

(b) "Spontaneous fetal death" means the expulsion or extraction of a product of human conception resulting in other than a live birth and which is not an induced termination of pregnancy; still birth.

(2) "File" means to present a vital record for registration by the state registrar.

(3) "Final disposition" means the burial, interment, cremation, removal from the state or other authorized disposition of a dead body or fetus.

(4) "Forms" means all certificates, forms, electronic media, reports, and records, and any safety paper used in their production, which are vital records.

(5) "Fraud manager" means an employee or representative of the bureau whose responsibilities include liaison with law enforcement, immigration, passport, embassy and consular officials, or other agencies, and who investigates or coordinates the investigation of any incidence or suspected incidence of fraud, or violation of statute or regulation, and who reports on these investigations to the state registrar.

G. Definitions beginning with "G":

(1) "Gender" means a person's internal sense of being male, female, some combination of male and female, or neither male nor female.

(2) "Given name" means a name that precedes one's surname.

H. Definitions beginning with "H":

(1) "Healthcare provider" for the purposes of medical aid in dying means an authorized individual pursuant to the End-of-Life Options Act to prescribe medical aid in dying including a physician licensed pursuant to the Medical Practice Act, an osteopathic physician licensed pursuant to the Osteopathic Medicine Act; A nurse licensed in advanced practice pursuant to the Nursing Practice Act, or a physicians assistant licensed pursuant to the Physicians Assistant Act or the Osteopathic Medicine Act.

(2) "Homeless" means the following:

(a) lacking a fixed, regular, and adequate nighttime residence;

(b) living in the housing of another person due to the individual's loss of housing, economic hardship or other reason related to that individual's lack of residence;

(c) living in a motel, hotel, trailer park or camping ground due to the lack of alternative adequate accommodation;

(d) living in an emergency or transitional shelter;

(e) sleeping in a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; or

(f) living in an automobile, a park, a public space, an abandoned building, substandard housing, a bus station, a train station or similar setting.

I. Definitions beginning with "I":

(1) "Immediate family" means any of the following: mother, father, grandmother, grandfather, grandchild, sibling, child or current spouse.

(2) "Institution" means any establishment, public or private, which provides in-patient or out-patient medical or surgical, or diagnostic care or treatment or nursing, custodial, or domiciliary care, or to which persons are committed by law.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": Live birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

M. Definitions beginning with "M":

(1) "Medical aid in dying" means the medical practice wherein a health care provider prescribes medication to a qualified individual who may self-administer that medication to end that individual's life in accordance with the provisions of the End-of-Life Options Act.

(2) "Minor error" means transposition of letters in words of common knowledge, typographical errors, or omissions of letters and numbers.

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O": "OMI" means the office of the medical investigator.

P. Definitions beginning with "P": "Physician" means a person authorized or licensed to practice medicine or osteopathy pursuant to the laws of New Mexico.

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R": "Registration" means the acceptance by the state registrar and the incorporation into his or her official records of vital records provided for in the act.

S. Definitions beginning with "S":

(1) "Sex" means the biological anatomy of an individual's reproductive system, and secondary sex characteristics.

(2) "State" means the state of New Mexico.

(3) "State registrar" means the person appointed under the Vital Statistics Act, Section 24-14-14, et seq., NMSA 1978, and whose duties are described in the act at Section 24-14-4 NMSA 1978.

(4) "System of vital statistics" means the registration, collection, preservation, amendment and certification of vital records; the collection of other reports required by this act; and activities related thereto, including the tabulation, analysis and publication of vital statistics.

T. Definitions beginning with "T": [RESERVED]

U. Definitions beginning with "U": [RESERVED]

V. Definitions beginning with "V":

(1) "Vital records" means certificates, records, reports, or registration forms of birth and death, and supporting documentation.

(2) "Vital statistics" means the data derived from certificates and reports of birth, death, spontaneous fetal death, induced termination of pregnancy and related reports.

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": "X" means a gender other than male or female, or an undesignated gender.

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[7.2.2.7 NMAC - Rp, 7.2.2.7 NMAC, 12/27/2022]

7.2.2.8 BUREAU OF VITAL RECORDS FORMS: All forms used in the system of vital statistics are the property of the department, and shall be returned to the state registrar upon demand. Only those forms prescribed, distributed and approved by the state registrar shall be used in the reporting of vital records and statistics or in making copies thereof. Such forms shall be used for official purposes only.

A. Requirements for the preparation of forms:

(1) All certificates, registration forms, reports and records relating to vital statistics must either be prepared in approved electronic form or on a typewriter or printer which prints in unfading ink. All signatures required shall be entered electronically, or in unfading ink, unless otherwise instructed in these or related regulations.

(2) Unless otherwise directed by the state registrar, no certificate, registration form, record or report shall be complete and acceptable for registration that:

(a) does not have the certifier's name typed or printed legibly with his or her signature;

(b) does not supply all items of information called for thereon or satisfactorily account for their omission;

(c) does not contain handwritten or approved electronic signatures, as required;

(d) includes alterations, including all manner of erasures, the use of correction fluids, and other correction devices;

(e) is marked "copy" or that is a carbon or photo or other copy;

(f) is prepared on an improper form;

(g) contains improper or inconsistent data;

(h) contains an indefinite cause of death which denotes only symptoms of disease or conditions resulting from disease;

(i) is not prepared in conformity with regulations or instructions issued by the state registrar.

B. Missing or unknown information: The state registrar shall request and be provided information from applicants, informants, or other interested parties if the registrar finds that information is missing, inconsistent, or listed as "unknown".

C. Copies of vital records: It is unlawful pursuant to Section 24-14-27 NMSA 1978 to copy or issue a copy of all or part of any record except as authorized by law.

[7.2.2.8 NMAC - Rp, 7.2.2.8 NMAC, 12/27/2022]

7.2.2.9 REGISTRATION OF BIRTH: A certificate of birth registration form for each live birth which occurs in this state shall be filed with the bureau within 10 days after the birth and shall be registered if it has been completed and filed in accordance with the Vital Records Act and related regulations. Exceptions shall be only those noted in the Vital Records Act or related regulations, or upon written authorization of the state registrar.

A. Infants of unknown parentage: Foundling registration. The report for an infant of unknown parentage shall be registered on a foundling report, and:

(1) show the required facts as determined by approximation and show parentage information as "unknown";

(2) show the signature and title of the custodian in lieu of the attendant.

B. Safe haven registration: If parentage information is known for a safe haven baby under the Safe Haven For Infants Act, Sections 24-22-1 to 24-22-8 NMSA 1978, (it shall be entered on the certificate of birth registration form for filing with the state registrar. If no parentage information is known, the certificate of birth registration form shall be completed as a foundling registration.

C. Birth registration - 11 days to one year: Birth registrations forms filed after 10 days, but within one year from the date of birth, shall be filed on the certificate of birth registration form in the

manner prescribed in Section 24-14-13 NMSA 1978. Certificates issued pursuant to the section shall not be marked "delayed."

(1) In any case where the certificate of birth registration form is signed by someone other than the licensed attendant or person in charge of the institution where the birth occurred, a notarized statement setting forth the reason therefore must be attached to the certificate. The state registrar may require additional evidence in support of facts of birth or an explanation why the certificate of birth registration form was not filed within the required 10 days.

(2) Out-of-hospital births not attended by a licensed medical attendant (physician, licensed certified nurse midwife, licensed midwife, emergency medical technician) must be signed by the mother as certifier, and sworn by any other person in attendance (if any other person was in attendance), and must be accompanied by notarized documents which prove both that a birth occurred and the New Mexico county in which the birth occurred. The state registrar will issue instructions containing a list of documents which will be acceptable as proof of birth, and as proof of residency.

[7.2.2.9 NMAC - Rp, 7.2.2.9 NMAC, 12/27/2022]

7.2.2.10 DELAYED CERTIFICATE OF BIRTH: All births presented for registration one year or more after the date of birth are to be filed on an application for delayed certificate of birth form or other format prescribed by the state registrar. No application for a delayed birth certificate shall be approved except by the state registrar or the deputy state registrar. No delayed certificate of birth shall be prepared for a person who is deceased.

A. Who may request the registration of and sign an application for a delayed birth certificate. Any person whose birth is not registered in this state, or his/her parent, or legal guardian, may request the registration of a delayed certificate of birth, subject to these regulations, evidentiary requirements and instructions issued by the state registrar. The application for each delayed certificate of birth shall be signed and sworn to before an official authorized to administer oaths, by the person whose birth is to be registered if such person is 18 years of age or over and is competent to sign and swear to the accuracy of facts stated therein; otherwise, the application shall be signed and sworn to by one of the following:

(1) one of the parents of the applicant for registration; or

(2) the legal guardian or court ordered custodian of the applicant for registration.

B. Facts to be established for a delayed registration of birth. The minimum facts which must be established by documentary evidence shall be the following:

(1) the full name of the person at the time of birth;

(2) the date of birth;

(3) the place of birth;

(4) the full maiden name of the mother; and

(5) the full name of the father, if paternity has been established pursuant to the Vital Records Act and related regulations or the Uniform Parentage Act.

C. Delayed registration following a legal change of status. When evidence is presented and accepted reflecting a legal change of status by adoption, legitimation, paternity determination, denial of paternity, or acknowledgment of paternity; an amended, delayed certificate may be established to reflect such change. The existing certificate and the evidence upon which the amended, delayed certificate was based shall be placed in a special file. Such file shall not be subject to inspection except upon order of a court or by the state registrar for purposes of properly administering the vital statistics program.

D. Documentary evidence requirements for delayed birth registration: To be acceptable for filing the following is needed to support a delayed registration of birth:

(1) to establish the name of the registrant; at least two pieces of documentary evidence;

(2) to establish the date of birth; at least two pieces of documentary evidence;

(3) to establish the place of birth; at least two pieces of documentary evidence.

(4) to establish facts of parentage; at least one piece of documentary evidence.

E. Documentary evidence - acceptability: The state registrar may establish a priority of the best evidence, and will determine the acceptability of any document submitted as evidence.

(1) Documents presented such as census, hospital, church and school records must be from independent sources and shall be in the form of the original record or a duly certified copy thereof.

(2) All documents submitted in evidence must have been established at least five years prior to the date of the first application for a delayed birth certificate, or have been established prior to the applicant's 10th birthday, and may not have been established for the purpose of obtaining a certificate.

(3) Affidavits of personal knowledge are not acceptable as evidence to establish a delayed certificate of birth.

(4) All documents submitted to support a delayed certificate of birth are subject to verification.

(5) If any fraudulent document is submitted in evidence, no delayed birth certificate shall be prepared, and the fraud manager shall be notified of the attempt.

(6) Examples of acceptable documentary evidence include but are not limited to the following:

(a) enrollment of service records;

(b) tribal records from tribal authorities;

(c) social security proof of application (NUMIDENT or SS 5 form);

(d) first application for marriage;

(e) first application for voter registration;

(f) medical records from a licensed hospital for a child five years and younger if the child was born in that facility and no other documentation is available.

(g) documents mentioned in Paragraph (1) of Subsection E of this section.

(7) Children five years or younger born outside of a licensed hospital without a midwife may not use the delayed birth registration process and must obtain an order from a court of competent jurisdiction to establish facts of birth pursuant to Section 24-14-16 NMSA 1978.

F. Documentary evidence - retention of copies, abstracts: The state registrar, or his or her designated representative, shall attach to the application for a delayed birth certificate, photo copies or an abstract and description of each document submitted to support the facts shown on the delayed birth certificate. All documents submitted in support of the delayed birth registration shall be returned to the applicant after review and use by the state registrar. The application and a copy of the documents submitted and accepted to support the delayed birth certificate shall be maintained in a permanent, confidential file.

If an abstract is used in lieu of photo copies it shall include the following information:

(1) the title or description of the document;

(2) the name and address of the custodian, if the document is an original or certified copy of a record;

(3) the date of the original filing of the document being abstracted;

(4) the information regarding the birth facts contained in the document.

G. Certification by the state registrar: The state registrar shall, by signature, certify that:

(1) no prior birth certificate is on file for the person whose birth is to be recorded;

(2) he or she has reviewed and accepted the evidence submitted to establish the facts of birth;

(3) the list of documents accepted as evidence which is entered on the delayed certificate of birth accurately reflects the documents accepted as evidence.

H. Rejection of applications for a delayed birth registration: If an applicant for a delayed registration of birth fails to submit the minimum documentary evidence required for a delayed registration of birth or if the state registrar finds reason to question the validity or adequacy of the certificate or the documentary evidence, the state registrar shall not register the delayed certificate and shall advise the applicant of the reason for such by final rejection letter, signed by the state registrar. The final rejection letter with notice of such will be deemed the rejection of the application and related certificate for purposes of Section 24-14-16 NMSA 1978. Applicants initially submitting evidence for a delayed certificate of birth may receive preliminary letters from the bureau requesting additional documentary evidence; such letters however shall not be considered the final rejection letter.

I. Court order for delayed certificates of birth. If an order from a court of competent jurisdiction to establish a delayed certificate of birth pursuant to Sections 24-14-15 and 24-14-16 NMSA 1978 is entered the state registrar shall require the applicant for the delayed certificate of birth to provide a duly certified copy of the court order and the related petition and supporting documents presented to the court to obtain such order, if the documents have not been previously received by the department. If the department was not given notice as required by statute of a hearing on a delayed birth certificate, the department and state registrar may seek legal redress.

J. Dismissal in six months: Applications for delayed certificates which have not been completed within six months from the date of initial application may be dismissed at the discretion of the state registrar. Upon dismissal, the state registrar shall so advise the applicant. A dismissal pursuant to this section shall not be considered a final rejection letter.

[7.2.2.10 NMAC - Rp, 7.2.2.10 NMAC, 12/27/2022]

7.2.2.11 THE CREATION OF AMENDED CERTIFICATES OF BIRTH FOLLOWING ADOPTION, LEGITIMATION, DENIALS OF PATERNITY AND ACKNOWLEDGEMENTS OF PATERNITY, AND OTHER LEGALLY RECOGNIZED DETERMINATIONS OF PARENTAGE:

A. Paternity: Upon receipt of a sworn acknowledgement of paternity signed by both parents, if no other person is shown as the father on the original certificate, a new certificate shall be prepared. A written request by both parents, if made within the 18 years of the child's birth, (unless acceptable proof is submitted that the mother is deceased, then by the father) that the minor child's surname be changed, and if no other person is shown as the father on the original certificate, a revised certificate shall be prepared. For a child aged 14 years or older, the child must give notarized consent to the change.

B. Court orders: If a person claims a change in paternity but cannot provide acknowledgement or denial of paternity as prescribed in the Uniform Parentage Act Section 40-11A-3 NMSA 1978, the person will be advised to seek a court adjudication of paternity.

C. An new certificate of birth shall be prepared by the state registrar for a child born in this state upon receipt of a certified copy of a court determination of parentage or other acceptable evidence of parentage as required by the state registrar pursuant to the provisions of the Vital Records Act and related regulations and the Uniform Parentage Act.

D. Creation of new certificate:

(1) The new certificate of birth prepared after adoption, a denial of paternity, legitimation, a determination of parentage, or an acknowledgement of paternity shall be prepared on the form in use at the time of its presentation, and shall include the following items and such other information necessary to complete the certificate:

(a) the name of the child;

(b) the date and place of birth as transcribed from the original certificate;

(c) the names and required personal information about the adoptive parent(s), the natural parent(s) or other legally recognized parents, whichever is applicable; and

(d) the original filing date.

(2) The information necessary to locate the existing certificate and to complete the amended certificate shall be submitted to the state registrar on a form prescribed by 7.2.2.8 NMAC.

E. Existing certificate - special filing of: Upon preparation of the amended certificate, the existing certificate and the evidence upon which the amended certificate was based shall be placed in a sealed file. Such file shall not be subject to inspection except upon order of a court of competent jurisdiction or by the state registrar for purposes of properly administering the vital statistics program.

[7.2.2.11 NMAC - Rp, 7.2.2.11 NMAC, 12/27/2022]

7.2.2.12 ADOPTION OF FOREIGN BORN:

A. Final Decree Requirements. On proof of adoption, a certificate of foreign birth shall be established by the state registrar for a person born in a foreign country who was not a citizen of the United States at the time of birth, provided the following conditions exist:

(1) the adopting parents are legal residents of New Mexico or members of the United States armed forces on active duty within the state of New Mexico;

(2) the child is adopted in New Mexico;

(3) a New Mexico court has issued an order recognizing the foreign adoption, if required;

(4) the department is provided a certified copy of the report of adoption and related court order;

(5) the final decree of adoption includes or is amended to include the following court findings:

(a) the probable country of birth;

(b) the year (and if known), the date and place of birth;

(c) a provision directing the state registrar to establish a certificate of birth.

B. Citizenship-limitations. The birth certificate form used by the state registrar in cases of foreign birth shall state on its face "this certificate is not evidence of United States citizenship."

C. Confidentiality. The evidence of adoption shall be sealed by the state registrar and shall not be subject to public inspection. The information shall be opened for inspection only upon court order, or upon the authorization of the state registrar in accordance with the Adoption Act.

D. Applicability. This section applies only to individuals born in foreign countries and who were neither born to U.S. citizens residing abroad nor naturalized as citizens prior to the adoption.

[7.2.2.12 NMAC - Rp, 7.2.2.12 NMAC, 12/27/2022]

7.2.2.13 REGISTRATION OF DEATH:

A. Registration

(1) When a death occurs in this state, a certificate of death shall be filed through the state's approved electronic system within five days after the death and prior to final disposition.

(a) The medical certification of death must be completed in the state's approved electronic system by the individual responsible for the medical certification.

(b) The demographic section of the certificate od death must be completed in the state's approved electronic system by the funeral practitioner or the person acting as such.

(2) Cases completed by tribal and federal entities will have up to 30 days after the receipt of medical records or autopsy, including toxicology results, to complete the medical certification section of the certificate of death in the state's approved electronic system with manner and cause of death. If these entities need additional time to complete the medical certification, they must contact the registrar within 30 days of death to request an extension.

(3) Cases referred to the office of the medical examiner will have up to 30 days after the receipt of medical records or autopsy, including toxicology results, to complete the medical certification section of the certificate of death in the state's approved electronic system with a manner and cause of death other than "pending". If the office of medical examiner needs additional time to complete the medical certification with manner and cause of death, they shall contact the state registrar prior to the expiration of time to request an extension.

(4) Certificates of death for indigent cases referred to a county shall be completed by the

county through the state's approved electronic system within 30 days of the indigent case assignment to the county.

(5) An extension of the required filing times for any portion of a certificate of death may be granted at the discretion of the state registrar to prevent undue hardship in accordance with Section 24-14-24 NMSA 1978.

(6) In all cases the medical certification must be signed by the person responsible for such certification. If the cause or manner of death is unknown or undetermined, each shall be listed as such on the certificate.

B. Incomplete certificate of death. If all the information necessary to complete the certificate of death is not available within the time prescribed for filing of the certificate, the funeral service practitioner shall file the certificate completed with all information that is available, and attach a note explaining why the incomplete items cannot be completed at the time of submission.

(1) The affidavit providing the information missing from the original certificate shall be filed with the state registrar as soon as possible, but in all cases within 30 days of the date of the death occurred unless otherwise specifically approved by the state registrar.

(2) When the affidavit results in changes to the existing certificate of death, such affidavit shall be considered an amendment; the certificate of death shall be marked "amended," and the affidavit shall be attached to the original certificate which is retained by the bureau.

C. Amendment of a certificate of death. Unless otherwise provided for in these regulations, the certificate of death may be amended only in the following manner:

(1) Statistical items: non-medical statistical items, including but not limited to: ethnicity, education, race and occupation may be amended when new facts become available. The affidavit/change procedure described in Paragraphs (1) and (2) of Subsection B of 7.2.2.13 NMAC shall be used. Additional evidence may be required by the state registrar.

(2) Date of death, place of death, time of death, date pronounced, time pronounced, manner of death, and any portion of the cause of death may not be changed through the use of an amended certificate. These items shall only be changed by the preparation and filing of a medical affidavit signed by the certifier.

(3) The amendment of medically related items and items related to injury may only be submitted by the office of the medical investigator or equivalent military or tribal authorities and only on the form prescribed by the state registrar. Should the certificate of death be revised, resulting in changes of referenced material, the state registrar shall advise customary users of the certificate of the changes.

(4) An amendment of the marital status at time of death shall be made only if it is:

(a) requested by the person listed as informant on the certificate of death, upon completion of the prescribed notarized affidavit form and presentation of acceptable documentation proving marital status at the time of death.

(b) requested by the funeral practitioner who provides an affidavit that the information as filed with the bureau was inconsistent with the information provided to such practitioner by the informant; or

(c) accompanied by a certified copy of a district court order directing the change in marital status, along with a copy of the petition for such order and evidence submitted to the court in support of the requested amendment, if such information was not previously supplied to the bureau.

D. Certificate of death occurring in a hospital or other institution and not under the jurisdiction of OMI. When a death occurs in a hospital or other institution, and the death is not under the jurisdiction of the office of the medical investigator, the person in charge of such institution, or his or her designated representative, may initiate the preparation of the certificate of death as follows.

(1) place the full name of the decedent and the date and place of death on the certificate of death, and obtain information on the method and place of disposition and enter on the disposition part of the certificate, and obtain from the certifier the medical certification of cause of death and the certifier's signature;

(2) present the partially completed certificate of death to the funeral service practitioner or person acting as such and advise them that they need to complete the missing items on the certificate and file it with the bureau of vital records and health statistics.

(3) for all deaths in which OMI assumes jurisdiction, including but not limited to a death without medical attendance and presumptive death, see OMI administrative rules at OMI 86-1.

E. Effect on other vital records.

(1) Upon death of a registrant, the registrant's birth certificate shall be marked with the word "deceased".

(2) If the death of an infant born alive occurs within two months of the date of the infant's birth, a family may receive one copy of a birth certificate without the "deceased" mark if the request is made with vital records state office within thirty days of the date of the infant's death.

(3) Unnamed birth certificates shall not be issued pursuant to this section. The child must be named at birth to obtain a birth certificate under this section.

(4) Amendments to a birth certificate, including but not limited to paternity, may not be made to a birth certificate

after that registrant's death certificate is registered.
[7.2.2.13 NMAC - Rp, 7.2.2.13 NMAC, 12/27/2022]

7.2.2.14 DELAYED REGISTRATION OF DEATH: The delayed registration of a death shall be registered in the manner prescribed below.

A. If the certifier, at the time of death and the attending funeral services practitioner or person who acted as such are available to complete and sign the certificate of death, it may be completed without additional evidence and filed with the state registrar. For those certificates of death filed one year or more after the date of death, the certifier or office of the medical investigator and the funeral service practitioner or person who acted as such must state in accompanying affidavits that the information on the certificate of death is based on records kept in their files.

B. In the absence of the certifier or office of the medical investigator and the funeral service practitioner or person who acted as such, the prescribed delayed certificate of death form may be filed by the immediate family of the decedent and shall be accompanied by:

(1) an affidavit of the person filing the certificate swearing to the accuracy of the information on the certificate;

(2) two documents which identify the decedent and his or her date and place of death, a summary of which shall be placed on the certificate.

C. The state registrar may reject a certificate of death or require additional documentary evidence to prove the facts of death, or in his or her discretion refer the case to the office of the medical investigator.
[7.2.2.14 NMAC - Rp, 7.2.2.14 NMAC, 12/27/2022]

7.2.2.15 DISPOSITION OF REPORTS OF INDUCED TERMINATION OF PREGNANCY: Reports of induced termination of pregnancy are statistical reports only and are not to be incorporated into the official records of the vital records and health statistics bureau, nor to be issued in any manner. The state registrar is authorized to dispose of the reports when all statistical processing of the records has been accomplished. However, the state registrar may establish a file of the records so they will be available for future statistical and research projects provided the file is not made a part of the official records and the reports are not made available for the issuance of certified copies. The file shall be retained for as long as the state registrar deems necessary, but in no case shall any report of induced termination of pregnancy be retained for longer than 18 months, and it shall then be destroyed. The file may be maintained by photographic, electronic, or other means as determined by the state registrar, in which case the original report from which the photographic, electronic or other file was made shall be destroyed. The provisions of Section 15 shall also apply to all records of induced termination of pregnancy filed prior to the adoption of this part.
[7.2.2.15 NMAC - Rp, 7.2.2.15 NMAC, 12/27/2022]

7.2.2.16 AUTHORIZATION FOR FINAL DISPOSITION:

A. Disposition of body. Before final disposition of a dead body or a fetus, the funeral service practitioner or person acting as such shall.

(1) Obtain assurance from the certifier that death is from natural causes and that the certifier will assume responsibility for certifying the cause of death or fetal death.

(2) For any case which comes under the jurisdiction of the office of the medical investigator, notify the office of the medical investigator and obtain authorization for removal and final disposition of a dead body or fetus.

B. Disposition of a dead body not under the supervision of a licensed New Mexico funeral service practitioner, direct disposer. When a death occurs in a hospital or other institution, and the disposition is not under the supervision of a licensed New Mexico funeral service practitioner, or direct disposer, the person in charge of such an institution or his or her designated representative shall:

(1) initiate the certificate of death or burial as follows:

(a) place the full name of the decedent and the date of death on the certificate of death registration form;

(b) obtain the information from the person to whom the body is being released and complete on the disposition section of the form the method and place of disposition; and

(c) obtain the medical certification of the cause of death from the certifier and the certifier's signature;

(2) obtain and verify through identification the full name and address of the person to whom the dead body is being released for disposition, and the place of disposition; and

(3) advise the person taking charge of the dead body of the statutory requirements to file the certificate of death registration form within 5 days, and prior to final disposition;

(4) send a photocopy of the partially completed certificate of death along with the name and address of the person who is not a funeral service practitioner, but who is acting as such, to the bureau of vital records and health statistics within five days;

(5) the original, partially completed copy of the registration form shall be completed by the person who is not a funeral service practitioner, but who is acting as such, to file within five days with the bureau of vital records and health statistics.

C. Filing of fetal death report. For any fetal death in which the fetus has attained at least twenty-week gestation or if gestational age is unknown, when the fetus weighs no less than 350 grams occurring in the state, a fetal death report shall be filed by the hospital, institution, physician, or, in the event the fetal death was unattended by any of the former, by the office of the medical investigator within 10 days and prior to final disposition. If a fetal death occurs with a midwife in attendance, the office of the medical investigator must be notified since New Mexico law limits pronouncement of death to a physician, certified nurse practitioner, or the office of the medical investigator. If a funeral service practitioner is aware that a fetal death occurred without medical attention, the funeral services provider shall notify the office of the medical investigator to initiate the report of fetal death. In all circumstances, a fetal death report must be initiated before the fetus is released for disposition.

D. Authorization for disinterment and reinterment. An authorization for disinterment and reinterment of a dead body shall be issued by the state registrar or state medical investigator on the form prescribed, upon receipt of a written request from the immediate family and the person who is in charge of the disinterment or upon receipt of an order of a court of competent jurisdiction directing the disinterment; and a certified copy of the death certificate if the death did not occur in New Mexico. A disinterment/ reinterment permit can only be issued to a licensed funeral service practitioner or direct disposer.

(1) Upon receipt of a court order or signed permission of the owner of the cemetery or burial ground, the state registrar or state medical investigator may issue one authorization to permit disinterment and reinterment of all remains in a mass disinterment. Insofar as possible, the remains of each body should be identified. The place of disinterment and reinterment shall be specified, including the cemetery name, the city, county and state of burial. The authorization shall be permission for disinterment, transportation and reinterment.

(2) Authorization shall be obtained from the state archaeologist for disinterment subject to the provisions of Section 18-6-11 NMSA 1978.

(3) A dead body properly prepared by an embalmer and deposited in a receiving vault shall not be considered a disinterment when removed from the vault for final disposition.

(4) No permit shall be issued for disinterment/ reinterment of a dead body within the boundaries of a single cemetery, but notice of such should be provided to the immediate family of the decedent. [7.2.2.16 NMAC - Rp, 7.2.2.16 NMAC, 12/27/2022]

7.2.2.17 AMENDMENT OF LIVE BIRTH AND DEATH CERTIFICATES: This section is intended to supplement previous sections regarding the amendment of live birth and death records.

A. Who may apply to amend a certificate - birth and death.

(1) To amend a birth certificate, application may be made by both parents, the legal guardian or court ordered custodian, the registrant if 18 years of age or over, a legal representative for the registrant or parents, or the individual responsible for filing the original certificate. On any request not made by the registrant for a child age fourteen years of age or older, the child must sign the application or give notarized consent to the change unless an amendment has been issued by a court of competent jurisdiction, and Subsection D of 7.2.2.17 NMAC of these regulations applies. This excludes Subsection F of 7.2.2.17 NMAC.

(2) To amend a certificate of death, application may be made by the informant or the funeral service practitioner or person acting as such who signed the certificate of death. Applications to amend the medical certification of cause of death shall be made only by the certifier who signed the medical certification or the office of the medical investigator. Other requested amendments shall be in conformance with these regulations and the Vital Records Act.

B. Minor errors.

(1) Correction of minor errors by the state registrar of a birth or death certificate: Correction of obvious minor errors, transposition of letters in words of common knowledge, or omissions may be made by the state registrar either upon his or her own observation or query.

(2) Correction of minor errors may be made upon request of the parents, legal guardian, or court ordered custodian of the registrant during the first year after birth. The certified certificate shall not be marked "amended."

C. Amendments of first or middle name. Unless otherwise provided for in these regulations or in statute, all applications for amendment to change the first or middle name on a vital record shall be supported by.

(1) An affidavit setting forth information to identify the certificate; the incorrect data as it is listed on the certificate; the correct data as it should appear, together with two or more items of acceptable documentary evidence which support the alleged facts and which were established at least five years prior to the date of the first application for amendment. For individuals five years or younger, acceptable documentary evidence shall be at the discretion of the state registrar.

(2) When minor corrections are made by the state registrar, a notation as to the source of the information, together with the date the change was made and the initials of the authorized agent making the change shall be made on the computer file, but shall not become a part of any certificate issued.

(3) The state registrar shall evaluate the evidence submitted in support of any amendment, and when they find reason to doubt its validity or adequacy the amendment may be rejected and the applicant advised of the reasons for this action.

(4) The bureau may also amend a record upon receipt of a certified court order for a name change made pursuant to the provisions of Section 40-8-1 NMSA 1978.

D. Other amendments.

(1) any application for amendment to change a last name on a vital record, except as otherwise provided in these regulations, shall be accompanied by a certified order from a court of competent jurisdiction;

(2) upon the receipt and acceptance of an acknowledgment of paternity affidavit, vital records will add the adjudicated father and if requested on the affidavit, the name of the child;

(3) amendment to the date of birth on a birth certificate shall be addressed as follows:

(a) the day of birth can be corrected with an affidavit upon proper submission of acceptable documentary evidence as long as the day of birth is not after the date the certificate is originally filed;

(b) changes to the month and year of birth shall be at the discretion of and in a manner prescribed by the state registrar; or

(c) as stated in a certified order by a court of competent jurisdiction.

(4) No name may be removed from a vital record without a court order;

(5) No amendments may be made to a birth certificate after the registrant is deceased without a court order.

(6) Any amendment to a vital record not addressed in these regulations shall be at the discretion of and in the manner prescribed by the state registrar.

E. Addition of given names - birth certificates. Given names, for a child whose birth was recorded without given names, may be added to the certificate upon written request of the registrant; or

(1) both parents; or

(2) the mother in the case of a child with no legally recognized father; or

(3) the father in the case of the death or incapacity of the mother; or

(4) the mother in the case of the death or incapacity of the father; or

(5) the guardian or agency having evidence of legal custody of the registrant; or

(6) any other legally recognized parent, legal guardian or court ordered custodian of a minor; or

(7) upon the receipt of an order by a court of competent jurisdiction.

F. Amendment of gender.

(1) A registrant if 18 years of age or older, born in New Mexico, or a registrant's parent, guardian, or legal representative, may amend the birth certificate to indicate a designated gender by providing the following:

(a) a completed gender designation change form provided by the bureau, along with a birth search application form;

(b) the statutorily required fee for the revision of a vital record pursuant to the New Mexico Vital Statistics Act. This fee shall include one certified copy of the amended record;

(c) a certified copy of an order from a court of competent jurisdiction changing the name of the registrant if applicable.

(2) Upon receipt of the required documentation, the gender designation will be changed to indicate male, female, or X.

(3) On any request not made by the registrant for a child age fourteen years of age or older, the child must sign the application or give notarized consent to the change unless an amendment has been issued by a court of competent jurisdiction.

G. Amendment of the same item more than once. Once an amendment of an item is made on a vital record, that item shall not be amended again except upon receipt of a certified court order.

H. When an applicant or informant does not submit the minimum documentation required in the regulations for issuing or amending a vital record, or when the state registrar has reasonable cause to question the validity or adequacy of the applicant's sworn statements or the documentary evidence submitted, the state registrar shall not issue or amend the vital record and shall advise the applicant of the reason for the action.

[7.2.2.17 NMAC - Rp, 7.2.2.17 NMAC, 12/27/2022]

7.2.2.18 CERTIFICATES OF STILL BIRTH:

A. Form of Fetal Death Report: The state registrar shall prescribe the form and content of a spontaneous fetal death report.

B. Application: The state registrar shall prescribe the form and content of an application for a certificate of still birth which shall specify the information necessary to prepare the certificate.

C. Form of certificate of still birth: The state registrar shall prescribe the form of a certificate of still birth and such form shall be distinct from the form for a certificate of live birth.

(1) A certificate of still birth shall include the state file number of the corresponding spontaneous fetal death report.

(2) The certificate of still birth shall contain the phrase "*This certificate of still birth cannot be used as proof of a live birth or for any other purpose".*

D. Information on certificate of still birth: If requested, the state registrar shall create a certificate of still birth based on the information contained in a report of spontaneous fetal death filed with the bureau in accordance with New Mexico law. The items listed in Section 24-14-22 1978 NMSA are not limited and may include the name of the father or second parent if the woman was married at the time of delivery or within 300 days. If the mother is not married, then the name of the biological father of the fetus can be added by completing an Acknowledgement of Paternity form.

E. Who may request a certificate of still birth: Only a person designated as a parent on a report of spontaneous fetal death may request and receive a certificate of still birth pertaining to that spontaneous fetal death.

F. Cost: Certificates of still birth will be issued upon receipt of the statutory fee to the requesting parent.

G. Amendments: The bureau will not accept or process requests for substantive amendments to a certificate of still birth. Minor or clerical errors may be remedied if information on the application for a certificate of still birth differs from the report of spontaneous fetal death filed with the bureau.

H. Retroactivity: The bureau shall create certificates of still birth for still birth events that occurred from January 1980 forward if a report of spontaneous fetal death was filed with the bureau. The bureau does not have information to create certificates of still birth for still birth events prior to January 1980. If data held by the bureau for the creation of retroactive certificates of still birth is incomplete, supplemental information may be provided by the mother at the time of application for a retroactive certificate and such information will be accepted at the discretion of the state registrar.

I. Retention of fetal death reports: Spontaneous fetal death reports filed after the finalization of this rule Section 7.7.2.18 NMAC shall be maintained as permanent records of the bureau. Spontaneous fetal death reports filed prior to the finalization of this rule, 7.2.2.18 NMAC, but maintained by the bureau pursuant to 7.2.2.15 NMAC (prior to amendment) shall be permanently maintained by the bureau to support the creation of retroactive certificates of still birth.
[7.2.2.18 NMAC - Rp, 7.2.2.18 NMAC, 12/27/2022]

7.2.2.19 RECORD PRESERVATION AND DESTRUCTION: When an authorized reproduction of a vital record has been properly prepared by the state registrar and when all steps have been taken to ensure the continued preservation of the information, the record from which the authorized reproduction was made may be disposed of by the state registrar. The record may not be disposed of, however, until the quality of the authorized reproduction has been tested to ensure that acceptable certified copies can be issued and until a security copy of the document has been placed in a secure location removed from the building where the authorized reproduction is housed. When no longer required for administrative use, the state registrar shall offer the original documents from which the authorized reproductions are made to the state records center and archives which shall be allowed to permanently retain the records pursuant to the restrictions in the vital statistics law and regulations related to access to such records. If the state records center and archives does not wish to place the records in its files the state registrar shall be authorized to destroy the documents upon receipt of written permission from state records and archives. The destruction shall be by approved methods for disposition of confidential or sensitive documents.
[7.2.2.19 NMAC - Rp, 7.2.2.19 NMAC, 12/27/2022]

7.2.2.20 DISCLOSURE OF RECORDS:

A. To protect the integrity of vital records the state registrar or other authorized custodian of vital records shall not permit inspection of, nor disclose information contained in vital statistics records, or copy or issue a copy of all or part of any vital record unless he or she is satisfied that the applicant has a direct and tangible interest in the record.

(1) The registrant, a member of the registrant's immediate family, the registrant's legal guardian or court ordered custodian, or any of their respective legal representatives, or an official of a federal or state government or of a political subdivision of the state charged by law with detecting or prosecuting crime, shall be considered to have a direct and tangible interest. Others may demonstrate a direct and tangible interest at the discretion of the registrar by providing certified documentary proof of such interest.

(2) The term "legal representative" shall include an attorney, executor of the estate, physician, funeral service practitioner, trust officer or other corporate fiduciary or other authorized agent acting on behalf of the registrant or his or her family.

(3) The natural parents of adopted children, when neither has custody, and business firms or other agencies requesting listings of names and addresses shall not be considered to have a direct and tangible interest.

B. The state registrar may permit the use of data from vital statistics records for statistical or research purposes, subject to those conditions the state registrar may impose. No data shall be furnished from records for research purposes until the state registrar has prepared or accepted, in writing, the conditions under which the records or data will be used, and the estimated or actual charges therefore and has received an agreement signed by a responsible agent of the agency or research organization agreeing to meet with and conform to the conditions.

C. The state registrar in their discretion may disclose copies or data from vital statistics records in accordance with the Vital Records Act and to federal, state, county, or tribal governments, or municipal agencies of government which the request data in the conduct of their official duties, except that any costs incurred by the bureau shall be the responsibility of the receiving agency.

D. Information from vital statistics records indicating a birth occurred to an unmarried woman may be disclosed only if it can be shown that disclosure of the information will be of benefit to the registrant.

E. The state registrar or authorized local custodian shall not issue a certified copy of a record until a signed application has been received from the applicant. Whenever the state registrar shall deem it necessary to establish an applicant's right to information from a vital record, the state registrar or local custodian may also require acceptable identification of the applicant or a sworn statement.

F. Nothing in this part shall be construed to permit disclosure of information contained in the "information for medical and health use only" section of the birth certificate unless specifically authorized by the state registrar for statistical or research purposes.

G. When 100 years have elapsed after the date of birth, provided the registrant is deceased, or 50 years have elapsed after date of death, the records in the custody of the state registrar shall become public records and any person may obtain copies of the record upon submission of an application containing sufficient information to locate the record and the payment of the proper fee.

H. No person except the parent or parents designated on a report of spontaneous fetal death shall be considered to have direct and tangible interest concerning that record of spontaneous fetal death and any resulting certificate of still birth.

[7.2.2.20 NMAC - Rp, 7.2.2.20 NMAC, 12/27/2022]

7.2.2.21 VITAL RECORDS: FORM AND REPRODUCTION OF RECORDS, VERIFICATION AND FRAUD:

A. Reproduction of records. Copies of vital records may be made by mechanical, electronic, or other reproductive process, except that the information contained in the "information for medical and health use only" section of the birth certificate shall not be included, except as provided by statute or regulation.

B. Form of records. The format of all certificates shall be at the discretion of the state registrar. Each non-memorial certificate to be authentic shall contain the seal of the state of New Mexico, the signature of the state registrar or authorized delegate, and a certification as prescribed.

C. Verification. Confidential verification of the facts contained in a vital record may be furnished by the state registrar to any federal, state, county or municipal government agency, or to any other agency representing the interest of the registrant, subject to and any limitations as provided for in these regulations. Verifications shall be on forms prescribed and furnished by the state registrar, or on forms furnished by the requesting agency and acceptable to the state registrar; or, the state registrar may authorize the verification in other ways when it shall prove in the best interests of his or her office. Costs incurred in the provision of the verification shall be the responsibility of the receiving agency.

D. Fraud. When the state registrar finds evidence that a certificate was requested or registered through misrepresentation or fraud, he or she shall have authority to withhold the issuance of the certificate. If any certificate has already been issued and cannot be recalled, the state registrar shall tag the record for non-issuance, and notify all concerned agencies of the presumption of fraud.

[7.2.2.21 NMAC - Rp, 7.2.2.21 NMAC, 12/27/2022]

7.2.2.22 MISSING CHILD REPORTING: Upon notification of the state registrar by a law enforcement agency that a child born in this state is missing, the record shall be flagged "M.C., do not issue" or electronically flagged.

A. Upon notification by a law enforcement agency that a child born outside this state is missing, the state registrar shall notify the corresponding officer in the state where the child was born that the child has been reported missing.

B. In response to any inquiry or request for a certificate, the state registrar or any appointed local registrar appointed by the state registrar shall not provide a copy of a birth certificate or information concerning the birth record of any missing child whose record is flagged, except following the notification of the law enforcement agency having jurisdiction over the investigation of the missing child.

C. Upon notification by a law enforcement agency that a missing child has been recovered, the state registrar shall remove the flag from the child's birth record.

[7.2.2.22 NMAC - Rp, 7.2.2.22 NMAC, 12/27/2022]

7.2.2.23 FEES FOR COPIES, SEARCHES AND OTHER SERVICES: No copy of a birth certificate or certificate of death shall be issued until the fee for the copy is received unless specific approval has been obtained from the state registrar or otherwise provided for by statute or regulation.

A. Each search for a birth certificate, death certificate, or certificate of still birth will be conducted upon receipt of the statutorily required fee pursuant to Section 24-14-29 NMSA 1978. The fee shall include one certified copy of the record, if available, and if no record is found the fee shall be non-refundable.

B. Delayed birth or death registration. A delayed record will be created upon receipt of the statutorily required fee pursuant to Section 24-14-29 NMSA 1978, and

shall include one certified copy of the delayed record.

C. An individual may have all fees waived by signing a form approved by the bureau attesting to the fact that they are homeless at the time of the request.

D. Amendments.

(1) Minor corrections. For the amendment of a record due to obvious errors, omissions on birth records (other than the name of the father), or transposition of letters in words of common knowledge, there shall be no charge.

(2) Major corrections. For the amendment of a record requiring the creation of an affidavit of correction or the submission of documentary evidence to support a change or correction to a record, the amendment will be made upon receipt of the statutorily required fee pursuant to Section 24-14-29 NMSA 1978, and shall include one certified copy of the amended record.

E. Multiple copies. additional copies, after those provided for in Subsections A. and B., and Paragraph (2) of Subsection C, of this section will be provided upon receipt of the statutorily required fee pursuant to Section 24-14-29 NMSA 1978.

F. Other. For any statistical research, other agency verification, data provision service or permit not specified in statute, the state registrar shall determine the fee for service on the basis of the costs of providing such services and determine the manner in which such costs must be paid.

G. Unnamed birth certificates: Birth certificates that were registered without a given name for the registrant will not be issued until the registrant is named, except to a government agency for their administrative use for a pending adoption of the child.

H. Administrative closures: All orders that have not been completed will be closed within six months of no activity and a new request must be made after an administrative closure. No fees will be returned or applied to the new request after an administrative closure.

[7.2.2.23 NMAC - Rp, 7.2.2.23 NMAC, 12/27/2022]

7.2.2.24 COURT ORDERS:

A. Court orders received by the bureau which order the amendment or creation of a vital records which are inconsistent with information known or maintained by the bureau may require the formal or other challenge of such if the bureau was not given notice of the related hearing or otherwise made aware of the proceeding prior to receiving the court order or was not provided with supporting documentary evidence relied on by the court to support its findings. Such action is necessary to protect the integrity and accuracy of the vital records held by the state registrar pursuant to state law.

B. The bureau will work cooperatively with tribal courts and authorities to meet the requirements of state law and the needs of the tribes.

C. Changes contained in a court order are only applicable to the person or persons specifically mentioned in the court order. A court ordered name change is only applicable to the registrant and will not operate as a method to amend any other vital record unless otherwise specified in the order.

[7.2.2.24 NMAC - Rp, 7.2.2.25 NMAC, 12/27/2022]

7.2.2.25 NAMING: For all parts of this section, any document in which a name is created or amended, the name given must comply with the following requirements:

A. must include a first and last name;

B. must be a full name and may not include initials;

C. may not be obscene, offensive, bizarre, or unduly lengthy;

D. may not be used for fraudulent purposes; and

E. may only use the 26 letters of the English alphabet and may not contain characters except hyphens, apostrophes, and periods.

[7.2.2.25 NMAC - N, 12/27/2022]

7.2.2.26 REPORTING; MEDICAL AID IN DYING:

A. A healthcare provider who prescribes medical aid in dying medication to an individual must fully complete the designated online form as soon as possible but in no case later than 30 days of issuing the prescription. The submitted form will be assigned a number for administrative purposes, and the form number will be sent to the healthcare provider who completed the designated form. The current version of the medical aid in dying reporting forms will be available for completion on the department website.

B. If after making reasonable efforts within 30 days of issuing the prescription, the healthcare provider is not aware of whether the prescription has been ingested, or if the prescription has not yet been ingested, the provider must complete the designated online form and mark either “not yet ingested” or “unknown”.

C. If a healthcare provider marks “not yet ingested” or “unknown” on the form, the healthcare provider must update that information online using the number assigned on the original form within 6 months of issuing the prescription. “Unknown” will not be accepted on the updated form. The department will send a reminder to the healthcare provider if an update has not been provided within 4 months of the initial online form submission.

[7.2.2.26 NMAC, 12/27/2022]

HISTORY OF 7.2.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the state records center:

HSSD 70-3, Amendment of Regulations Governing Preservation, Disposition, Transportation, Interment and Disinterment of Dead Human Bodies, filed 2/17/1970.

HSSD 77-7, Regulations Governing the Reporting, Transporting, Storing, Preserving and Disposing of Dead Human Bodies and Fetal Remains (Stillborns), filed 10/12/1977.

HED 79-HSD-3, Regulations

Governing the Disposition of Human and Fetal Remains, filed 10/11/1979.
HSSD 77-5, Regulations Governing the New Mexico Vital Statistics Act, filed 7/26/1977.
HSSD 77-6, Regulations Governing the Reporting, Filing and Use of Reports of Induced Abortion, filed 8/9/77.
HED-82-5 (HSD), Vital Statistics Regulations, filed 7/28/1982.
HED 89-7 (PHD), Regulations Governing New Mexico Vital Records and Statistics, filed 8/21/1989.

History of Repealed Material:
7 NMAC 2.2, Vital Records and Statistics (filed 10/18/96) repealed 12/30/2010.
7.2.2 NMAC - Vital Records and Statistics (filed 12/15/2010) repealed 10/29/2019.
7.2.2 NMAC - Vital Records and Statistics (filed 10/17/2019) repealed 12/27/2022.

Other History:
HED 89-7 (PHD), Regulations Governing New Mexico Vital Records and Statistics (filed 8/21/89) was renumbered, reformatted, amended and replaced by 7 NMAC 2.2, Vital Records and Statistics, effective 10/31/1996.
7 NMAC 2.2, Vital Records and Statistics (filed 10/18/1996) was renumbered, reformatted and replaced by 7.2.2 NMAC, Vital Records and Statistics, effective 12/30/2010.
7.2.2 NMAC - Vital Records and Statistics (filed 12/15/2010) was replaced by 7.2.2 NMAC - Vital Records and Statistics, effective 10/29/2019.
7.2.2 NMAC - Vital Records and Statistics (filed 10/17/2019) was replaced by 7.2.2 NMAC - Vital Records and Statistics, effective 12/27/2022.

HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.102.461 NMAC, Section 12 effective 1/1/2023.

8.102.461.12 SUBSIDIZED PRIVATE SECTOR EMPLOYMENT (Core Activity):

A. Employment for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing a participant is considered to be subsidized private sector employment.

B. General: New Mexico will use TANF funds to offset the wages of employing a TANF participant for an established period of time. Upon expiration of the subsidized term of employment, the employer is expected to hire the participant. This income will be excluded for determining TANF eligibility.

C. Component activities: The following shall be considered as qualified participation hours for subsidized private sector employment.

(1) Employment will be considered subsidized if the employer receives TANF or other public sector funding for an employee.

(2) Public sector paid apprenticeships and paid internships shall be considered subsidized employment.

D. Supervision and documentation: Hours of participation in an employment-related activity will be projected, based on actual hours worked, for up to six months at which time current documentation shall be required in order to evaluate any changes in the prospective hours of participation.
[8.102.461.12 NMAC - Rp, 8.102.460.21 NMAC, 04/01/2012; A, 1/1/2023]

HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.102.520 NMAC, Section 9 effective 1/1/2023.

8.102.520.9 EXEMPT INCOME: The following income sources are not considered available for the gross income test, the net income test, and the cash payment calculation:

A. medicaid;

B. food stamp benefits;

C. government-subsidized foster care, if the child for whom the payment is received is not included in the benefit group;

D. SSI;

E. government-subsidized housing or a housing payment; government includes any federal, state, local or tribal government or a private non-profit or for profit entity operating housing programs or using governmental funds to provide subsidized housing or to make housing payments;

F. income excluded by federal law (described in 8.139.527 NMAC);

G. educational payments made directly to an educational institution;

H. government-subsidized child care;

I. earned income that belongs to a child 17 years of age or younger who is not the head of household; only earned income paid directly to the child is considered as belonging to the child;

J. up to $50.00 child support disregard and [~~up to~~] $100.00 for one child and $200 for two or more children per month, child support pass-through distributed to the benefit group by the CSED;

K. an emergency one-time only payment made by other agencies or programs;

L. reimbursements for past or future identified expenses, to the extent they do not exceed actual expenses, and do not represent a gain or benefit to the benefit group, such as expenses for job or job training related activities, travel, per diem, uniforms, transportation costs to and from the job or training site, and medical or dependent care reimbursements and any reimbursement for expenses incurred while participating in NMW work program activities; reimbursements for normal living expenses, such as

rent, mortgage, clothing or food eaten at home are not excluded;

M. utility assistance payments such as from low-income home energy assistance program (LIHEAP), low-income assistance program (LITAP), or similar assistance programs;

N. subsidized private sector employment: as outlined at Subsection B of 8.102.461.12 NMAC. [8.102.520.9 NMAC - Rp 8.102.520.8.I NMAC, 07/01/2001; A, 11/15/2007; A, 07/15/2010; A, 1/1/2023]

HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is amendment to 8.102.620 NMAC, Section 10 effective 1/1/2023.

8.102.620.10 CHILD SUPPORT AND NMW NON-COOPERATION PAYMENT SANCTIONS:

A. General:

(1) The benefit group shall be subject to a non-cooperation payment sanction under either or both of the following circumstances:

(a) failure by a benefit group member to meet NMW requirements; or

(b) failure by the adult responsible for children included in a benefit group to meet child support enforcement division (CSED) cooperation requirements or both;

(c) good cause will be evaluated based on the circumstances of each instance of non-cooperation.

(2) Occurrence of non-cooperation:

(a) Child support:

(i) A benefit group shall be subject to a payment sanction for failure to comply with CSED cooperation requirements, even if the adult required to cooperate with child support requirements is not included in the benefit group.

(ii) Each benefit group member that fails to cooperate with the NMW requirement is subject to a sanction and shall affect the benefit group.

(iii) An occurrence of non-cooperation shall be applied when a sanction progresses to the next sanction level as a result of the noncompliance continuing for three consecutive months without the sanctioned participant reestablishing compliance. Progression to the next sanction level shall be effective in the fourth month.

(iv) A first or second level sanction is considered to be cured upon full cooperation by the sanctioned participant or a sanction shall be reversed based on a hearing decision when the sanction imposed is determined to be invalid.

(b) NMW:

(i) A benefit group is subject to a payment sanction when a participant in the benefit group fails to cooperate with the NMW requirements absent a finding of good cause.

(ii) In a two-parent benefit group, each mandatory benefit group member that fails to cooperate with the NMW requirements is subject to a sanction that affects the benefit group's sanction level and payment.

(iii) A participant shall not be sanctioned for more than one NMW requirement element at one time. A participant may be sanctioned for the same or a different NMW requirement element only after the original sanction element is cured or reversed. A first or second level sanction may be cured upon full cooperation by the sanction participant and a sanction shall be reversed based on a hearing decision when the sanction imposed is determined to be invalid.

(iv) A participant with limited participation status may not be sanctioned [for failure to meet hours or failure to provide a time sheet as identified on the approved work participation agreement.

(iv) A participant with limited participation status may not be sanctioned [~~for failure to meet the work participation requirement~~] for failure to meet hours or failure to provide a time sheet [~~rates~~] as identified on the approved work participation agreement.

(v) An occurrence of non-cooperation shall be applied when a sanction progresses to the next sanction level as a result of the noncompliance continuing for three consecutive months without the sanctioned participant reestablishing compliance. Progression to the next sanction level shall be effective in the fourth month.

(3) Cumulative sanctions:

(a) Non-cooperation sanctions are cumulative within the benefit group and shall occur when:

(i) the participant fails to comply with the NMW and child support enforcement requirements;

(ii) more than one participant in the benefit group have failed to comply with either the NMW and child support enforcement requirement.

(b) Cumulative sanctions, whether or not cured, shall remain the property of that benefit group participant who caused the sanction.

(i) A participant with a sanction who leaves a benefit group relieves the benefit group of that participant's sanction status.

(ii) A participant with a sanction who joins another benefit group subjects the new benefit group to any sanction or sanction level that has not been cured prior to joining the benefit group.

(c) The benefit group's cumulative sanctions and benefit level shall be reevaluated when a sanction is cured or reversed.

(4) Progressive sanctions:

(a)
Non-cooperation sanctions are progressive to both the participant and to the benefit group and shall progress to the next level for the benefit group in which the sanctioned participant resides when:

(i)
a participant fails to establish compliance in three-month increments; or

(ii)
a participant fails to comply with NMW or CSED requirements as a separate occurrence.

(b)
A sanction that is not cured for three consecutive months shall progress until compliance is established by the participant.

(c)
A participant's compliance cannot reverse the sanction level attributed to the benefit group. Any subsequent sanction is imposed at the next higher level, unless reversed by a hearing decision.

B. The conciliation process:

(1)
When conciliation is available: Conciliation shall be available to a participant or applicant once during an occurrence of assistance. There must be a period of at least 12 months between occurrences of cash assistance in order for a conciliation to be available again to the benefit group. NMW conciliation and child support conciliation are independent and are counted separately from each other.

(2)
Determining that noncompliance has occurred:

(a)
The determination of noncompliance with child support shall be made by CSED. The conciliation and sanctioning process for child support noncompliance is initiated upon receipt of notice from CSED that the participant or applicant has failed to cooperate. Under 8.102.420 NMAC, the non-cooperative participant or applicant shall be individually disqualified from participation in the benefit group.

(b)
The determination of noncompliance with NMW requirements shall be made by the caseworker. A finding of noncompliance shall be made if:

(i)
the participant has not completed an assessment;

(ii)
the participant fails or refuses to complete an IRP;

(iii)
the participant fails or refuses to submit an approvable WPA;

(iv)
the participant fails to submit timely documentation showing completion of required work hours;

(v)
the participant's monthly attendance report shows fewer than the minimum required hours of participation and no other allowable hours of activity can be reasonably attributed by the caseworker towards the monthly participation requirement.

(3) Initiating conciliation: Within 10 days of determining that noncompliance exists, the caseworker shall take action to initiate a conciliation, if the participant's conciliation has not been used. A conciliation is initiated by the department or its designee issuing a conciliation notice. CSED shall determine noncompliance and notify the caseworker who shall initiate the conciliation process.

(4)
Conciliation period: Conciliation gives a participant a 30-calendar day period to correct the current non-compliance for either a NMW participation or CSED requirement.

(a)
The conciliation process is established by the department, to address the noncompliance, identify good cause for noncompliance or barriers to compliance and shall occur only once prior to the imposition of the sanction.

(i)
The participant shall have ten working days from the date a conciliation notice is mailed to contact the department to initiate the conciliation process. A participant who fails to initiate the conciliation process shall have a notice of adverse action mailed to him after the 10th working day following the date on which the conciliation notice is mailed.

(ii)
Participants who begin but do not complete the conciliation process shall be mailed a notice of adverse action 30 days from the date the original conciliation was initiated. The benefit group shall be subject to sanction in the month following the month the notice of adverse action expires.

(b)
Non-cooperation with CSED requirements: When the participant has initiated the conciliation process, it is the participant's responsibility to contact CSED and to comply with requirements or to request a waiver from CSED due to good cause. If the caseworker does not receive confirmation from CSED within 30 days of issuing the conciliation notice that the participant is cooperating or has requested a waiver for good cause in accordance with 8.50.105.14 NMAC; the conciliation process shall be considered to have failed the benefit group shall be subject to payment sanctioning.

(c)
The caseworker shall make the determination whether arrangements have been made to meet NMW requirements or whether there is good cause for waiving the cooperation requirements. If arrangements to meet the requirement or to waive it have not been made by the 30th day following issuance of the conciliation notice, the conciliation shall be considered to have failed and the participant is subject to sanctioning.

C. Sanctioning:

(1) Within 10 days of determining that a participant has failed to meet a NMW requirement, department or its designee shall issue notice of adverse action that the payment shall be reduced. The payment reduction shall take place with the first payment following expiration of the notice of adverse action.

(2) Notice of adverse action shall apply to all NMW

and child support noncompliance sanctions, including those relating to the conciliation process.

(3) A participant who corrects the failure of compliance with NMW or child support enforcement requirements during the notice of adverse action 13-day time period shall not have the sanction imposed against the benefit group or payment amount. The sanction shall not count as a cumulative or progressive sanction, since the reason for the sanction was corrected during the time period of the notice of adverse action and prior to a benefit reduction being imposed. A participant who has failed to meet work participation hours cannot correct the sanction during the notice of adverse action time period.

(4) Failure to comply during the notice of adverse action 13-day time period shall cause the sanction to become effective for a minimum of one month. If the participant later complies with the NMW compliance requirements, as determined by the department, the sanction may be removed, so long as the participant has received at least one month of reduced benefit due to sanction.

(a) A child support enforcement sanction shall be removed after CSED notifies the caseworker that the participant is in compliance with child support enforcement requirements.

(b) A NMW sanction shall be removed after the caseworker receives verification that the participant has completed an assessment; or has completed an IRP; or has completed a WPA that indicates the appropriate number of monthly hours in work activities; or has met NMW participation hours for at least 30 days; or has good cause to waive work participation requirements.

D. Sanction levels:

(1) First-level sanction:

(a) The first level sanction for failure to comply shall result in a sanction of twenty-five percent of the standard of need. The benefit group shall be given notice of the imposition of the sanction.

(b) A first level sanction that is not cured for three consecutive months shall progress to a second level sanction.

(2) Second-level sanction:

(a) The second level of sanction for failure to comply shall result in a decrease of fifty percent of the standard of need. The second level shall be initiated by:

(i) failure to comply with NMW participation or child support enforcement requirements for more than three months; or

(ii) a second occurrence of noncompliance with a NMW or CSED requirement by a participant; or

(iii) failure of a participant to comply with both CSED and NMW participation requirements simultaneously. The group shall be given concurrent notice of imposition of the second-level sanction.

(b) A second level sanction that is not cured for three consecutive months shall progress to the third level as described below.

(3) Third-level sanction:

(a) The third sanction level is case closure for a period of not less than six months. The group shall be given notice of adverse action prior to imposition of the sanction.

(i) Once a participant is sanctioned at the third level, any subsequent occurrence of failure to comply with NMW or CSED requirements shall immediately result in a third level sanction, and case ineligibility for six months.

(ii) The TANF grant will be counted as unearned income for SNAP benefits for the six month period of ineligibility in accordance with 8.139.520 NMAC.

(b) TANF applications received after a six month closure period will be reviewed for eligibility.

(i) Based on eligibility the TANF will be approved and all mandatory members will be required to meet the NMW compliance requirements set forth in 8.102.460 NMAC;

(ii) If ISD determines the applicant is still non-compliant with CSED, the sanction will remain and the application will be denied.

E. Sanctions by other states or other programs: Participants in sanction status for failure to participate in other programs, such as the food stamp E&T program, or another state's or tribal TANF program, shall not carry that sanction status into NMW.

F. Sanctions with respect to voluntary participants: A voluntary participant is not subject to sanction for failure to participate, but shall be removed from the NMW and lose eligibility for support services

G. Good cause:

(1) Good cause applies to timely completion of assessment, IRP, WPA, work participation rates, and cooperation with the child support enforcement division.

(2) Good cause for failure to meet the NMW requirements.

(a) Good cause may be considered to exist for no more than 30 days in the event of:

(i) family death;

(ii) hospitalization;

(iii) major injury to the participant or a benefit group member for whom the participant has been the primary caretaker;

(iv) reported domestic violence;

(v) catastrophic event; or

(vi) it is shown the department did not

provide the participant reasonable assistance to complete the assessment, IRP, or WPA.

(b) The participant must meet with the NMW service provider prior to the end of the 30-day period to establish a WPA for the full participation standard beginning on day 31 or must request a limited work participation status prior to the end of the 30-day period. The participant may be subject to sanction for failure to complete a WPA if a new WPA has not been established by day 31.

(i) A participant with good cause for failure to meet the NMW requirements, who expects the cause of failure to continue for more than 30 days, must contact the department to review the participant's circumstances.

(ii) Under no conditions shall good cause be granted for more than 30 days during any given reporting period.

(3) Good cause shall be considered when the department has failed to submit a notice in accordance with the requirements of adverse action notices, to the participant or provide available support services that would adversely affect the participant's ability to timely meet work participation requirements.

(4) Good cause for refusal to cooperate with the child support enforcement requirements: In some cases it may be determined by the CSED that the TANF/NMW applicant's/recipient' refusal to cooperate is with good cause in accordance with 8.50.105.14 NMAC. Any person requesting a good cause exemption to a TANF/NMW requirement to cooperate must complete a request for a good cause exemption on a form provided by the CSED and provide any documentation requested by CSED. The request for a good cause exemption will be reviewed by the CSED and the requestor will be informed of the decision in writing. The requestor's failure or refusal to complete the form or provide the requested documentation will result in an automatic denial of the request. The department may offer assistance to complete the form or obtain the necessary documentation, as appropriate.

(5) It is the applicant's/recipient's responsibility to inform the department if they are unable to meet the NMW compliance requirements or CSED cooperation requirements.

[8.102.620.10 NMAC - Rp 8.102.620.10 NMAC, 07/01/2001; A, 02/14/2002; A, 11/15/2007; A, 04/01/2012; A, 07/01/2013; A, 09/01/2017; A, 1/1/2023]

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

The New Mexico Human Services Department approved the repeal of 8.302.1 NMAC - Medicaid General Provider Policies, General Provider Policies (filed 6/14/2001) and replaced it with 8.302.1 NMAC - Medicaid General Provider Policies, General Provider Policies (adopted on 12/9/2022), effective 1/1/2023.

The New Mexico Human Services Department approved the repeal of 8.310.3 NMAC - Health Care Professional Services, Professional Providers, Services and Reimbursement (filed 12/17/2013) and replaced it with 8.310.3 NMAC - Health Care Professional Services, Professional Providers, Services and Reimbursement (adopted on 12/9/2022), effective 1/1/2023.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 1 GENERAL PROVIDER POLICIES

8.302.1.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.302.1.1 NMAC - Rp, 8.302.1.1 NMAC, 1/1/2023]

8.302.1.2 SCOPE: The rule applies to the general public.
[8.302.1.2 NMAC - Rp, 8.302.1.2 NMAC, 1/1/2023]

8.302.1.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).
[8.302.1.3 NMAC - Rp, 8.302.1.3 NMAC, 1/1/2023]

8.302.1.4 DURATION: Permanent.
[8.302.1.4 NMAC - Rp, 8.302.1.4 NMAC, 1/1/2023]

8.302.1.5 EFFECTIVE DATE: January 1, 2023, unless a late date is cited at the end of a section.
[8.302.1.5 NMAC - Rp, 8.302.1.5 NMAC, 1/1/2023]

8.302.1.6 OBJECTIVE: The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.302.1.6 NMAC - Rp, 8.302.1.6 NMAC, 1/1/2023]

8.302.1.7 DEFINITIONS:
"Medically necessary services"

A. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(1) are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;

(2) are delivered in the amount, duration, scope and setting that is clinically

appropriate to the specific physical and behavioral health care needs of the eligible recipient;

(3) are provided within professionally accepted standards of practice and national guidelines; and

(4) are required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the provider or the payer.

B. Application of the definition:

(1) A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.

(2) The department or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient shall do so by:

(a) evaluating the eligible recipient's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems.

(3) Physical and behavioral health services shall not be denied solely because the eligible recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.

(4) Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age shall be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.

(5) Medically necessary service requirements apply to all medical assistance program rules.

[8.302.1.7 NMAC - Rp, 8.302.1.7 NMAC, 1/1/2023]

8.302.1.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.302.1.8 NMAC - Rp, 8.302.1.8 NMAC, 1/1/2023]

8.302.1.9 GENERAL PROVIDER POLICIES: Medically necessary services are reimbursed by the MAD under Title XIX of the Social Security Act as amended, or by state statute.

[8.302.1.9 NMAC - Rp, 8.302.1.9 NMAC, 1/1/2023]

8.302.1.10 ELIGIBLE PROVIDERS:

A. Upon the approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. 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, billings instructions, utilization review instructions, and other pertinent materials. When enrolled, providers receive instructions on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement and all applicable statutes, regulations and executive orders.

B. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.302.1.10 NMAC - Rp, 8.302.1.10 NMAC, 1/1/2023]

8.302.1.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS: A provider who furnishes services to a medicaid eligible recipient agrees to comply with all federal and state laws, regulations, and executive orders relevant to the provision of services. A provider also must conform to MAD program rules, instructions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. A provider must verify that individuals are eligible for a specific health care program administered by the HSD and its authorized agents and must verify the eligible recipient's

enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

A. Eligibility determination: A provider must verify recipient eligibility prior to providing services and verify that the recipient remains eligible throughout periods of continued or extended services.

(1) A provider may verify eligibility through several mechanisms, including using the automated voice response system, contacting MAD or designated contractor eligibility help desks, contracting with an eligibility verification system vendor, or by using the New Mexico medicaid portal.

(2) An eligible recipient becomes financially responsible for a provider claim if the eligible recipient:

(a) fails to identify themselves as a MAD eligible recipient; or

(b) fails to state that an eligibility determination is pending; or

(c) fails to furnish MAD identification before the service is rendered and MAD denies payment because of the resulting inability of the provider to be able to file a claim timely; or

(d) receives services from a provider that lacks MAD enrollment, is not eligible to provide the services or does not participate in MAD programs.

B. Requirements for updating information: A provider must furnish MAD or the appropriate MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the provider or person. MAD or the appropriate MAD claims processing contractor must receive this information at least 60 calendar days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment or provider repayment. The provider must provide MAD with information, in writing, updating their provider participation agreement of any conviction of delineated criminal or civil offenses against the provider or parties with direct or indirect ownership or controlling interest within ten calendar days after the conviction.

C. Additional requirements: A provider must meet all other requirements stated in the program rules, billing instructions, manual revisions, supplements, and signed application forms or re-verification forms, as updated. MAD may require a letter of credit, a surety bond, or a combination thereof, from the provider. The letter of credit, surety bond or combination thereof may be required if any one of the following conditions is met:

(1) the provider is the subject of a state or federal sanction or of a criminal, civil, or departmental proceeding in any state;

(2) a letter of credit, surety bond, or any combination thereof is required for each provider of a designated provider type;

(3) the provider cannot reasonably demonstrate that they have assumed liability and are responsible for paying the amount of any outstanding recoveries to MAD as the result of any sale, merger, consolidation, dissolution, or other disposition of the provider or person; or

(4) the secretary determines that it is in the best interest of MAD to do so, specifying the reasons.

[8.302.1.11 NMAC - Rp, 8.302.1.11 NMAC, 1/1/2023]

8.302.1.12 ELIGIBLE MEDICAID RECIPIENTS: To comply with Title XIX of the Social Security Act, as amended, MAD is required to serve certain groups of eligible recipients and has the option of paying for services provided to other eligible recipient groups [42 CFR 435.1]. MAD is also required to pay for emergency services furnished to non-citizens residing in New Mexico who are not lawfully admitted for permanent residence but who otherwise meet the eligibility requirements. Coverage is restricted to those services necessary to treat an emergency medical condition, which includes labor and delivery services. See 8.325.10.3 NMAC.

A. Recipient eligibility determination: To be eligible to receive MAD benefits, an applicant/recipient must meet general eligibility or resource and income requirements. These requirements vary by category of eligibility and may vary between health care programs. See 8.200 NMAC for information on medicaid eligibility requirements.

(1) An otherwise eligible recipient who is under the jurisdiction or control of the correctional system or resides in a public institution is not eligible for medicaid.

(2) MAD eligibility determinations are made by the following agencies:

(a) the staff of the income support division (ISD) county offices determines eligibility for medicaid categories of eligibility;

(b) the staff of the New Mexico children, youth and families department (CYFD) determines eligibility for child protective services, adoptive services and foster care children;

(c) the staff of the social security administration determines eligibility for social security income (SSI); and

(d) the staff of a federally qualified health center, a maternal and child health services block grant program,

the Indian health service, and other designated agents make presumptive eligibility determinations.

B. Recipient freedom of choice: Unless otherwise restricted by specific health care program rules, an eligible recipient has the freedom of choice to obtain services from in-state and border providers who meet the requirements for MAD provider participation. Some restrictions to this freedom of choice apply to an eligible recipient who is assigned to a provider or providers in the medical management program (45 CFR 431.54 (e)). See 301.5 NMAC, *Medical Management.* Some restrictions to this freedom of choice may also apply to purchases of medical devices, and laboratory and radiology tests and other services and items as allowed by federal law (42 CFR 431.54 (d)).

C. Recipient identification: An eligible recipient must present all health program identification cards or other eligibility documentation before receiving services and with each case of continued or extended services.

(1) A provider must verify the eligibility of the recipient to assure the recipient is eligible on the date the services are provided. Verification of eligibility also permits the provider to be informed of any restrictions or limitations on services associated with the recipient's eligibility; of the applicability of co-payments on services; of the need for the eligible recipient's care to be coordinated with or provided through a managed care organization, a hospice provider, a PACE provider, a medical management provider, or similar health care plan or provider. Additionally, information on medicare eligibility and other insurance coverage may be provided.

(2) An eligible recipient whose health care program coverage or benefits may be limited include:

(a) qualified medicare beneficiary (QMB) recipient; and

(b) family planning benefits.

[8.302.1.12 NMAC - Rp, 8.302.1.12 NMAC, 1/1/2023]

8.302.1.13 PATIENT SELF DETERMINATION ACT: A hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, hospice agency and home health agency is required to give an eligible recipient or personal representative information about their right to make their own health decisions, including the right to accept or refuse medical treatment, pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990. An eligible recipient is not required by this legislation to execute advance directives. Advance directives, such as living wills or durable power of attorney documents, must be established in a manner which is recognized under New Mexico state law. See applicable state law. A health care provider cannot object on the basis of conscience when an eligible recipient or personal representative wishes to implement an advance directive.

A. Information requirements: At the time of admission, a provider is required to provide written information to an adult eligible recipient or personal representative concerning their right to do the following:

(1) make decisions about their medical care;

(2) accept or refuse medical or surgical treatment;

(3) execute advance directives;

(4) execute their rights under HIPAA; and

(5) if an eligible recipient who is already incapacitated is admitted, the provider must provide their personal representatives with this information; if an eligible recipient is no longer incapacitated, the provider must discuss these rights with the eligible recipient.

B. Policies, rules and procedures: A provider must give written information to an eligible adult recipient or their personal representative about provider rules and procedures concerning advance directive rights. A provider must verify that the advance directive complies with state law.

C. Documentation requirements: A provider must document in each eligible recipient's medical record whether their personal representative has established an advance directive. If the eligible recipient or their personal representative presents an advanced directive, a provider must comply with the terms of the document, as directed by state law. If an eligible recipient is incapacitated, unable to communicate, or their personal representative does not present an advance directive, the provider must document that the eligible recipient was unable to receive information or communicate whether advance directives exist. A provider must inform the eligible recipient or their personal representative that it furnishes information and proper forms for completion of advance directives.

D. Provision of care: A provider must not condition the provision of care or discriminate against an eligible recipient based on whether they have established advance directives. If an eligible recipient is entitled to necessary care ordered by a physician, which providers under normal procedures must furnish, care cannot be delayed while waiting for the execution of an advance directive. Once the existence of an advance directive is documented, the directive takes precedence over normal procedures.

E. Changing the advanced directives: A provider must inform an eligible recipient or their personal representative that they have a right to reaffirm an advance directive or change an advance directive at any time and in any manner, including oral statements.

[8.302.1.13 NMAC - Rp, 8.302.1.13 NMAC, 1/1/2023]

8.302.1.14 NONDISCRIMINATION: A provider must furnish covered services to an eligible recipient in the same scope, quality and manner as provided to the general public. Within the limits of medical assistance programs, a provider may not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, marital status, political belief, or source of payment, (45 CFR 80.3 (a)(b); 45 CFR 84.52 (a); 42 CFR 447.20; and PL 101-366, 104 Stat. 327 (1990)).
[8.302.1.14 NMAC - Rp, 8.302.1.14 NMAC, 1/1/2023]

8.302.1.15 BILLING AND CLAIMS PROCESSING: Reimbursement to a provider for services or procedures is based on the MAD reimbursement fee schedule, reimbursement rate, or reimbursement methodology in place at the time the services were furnished by the provider. A provider who furnishes services to an eligible recipient agrees to accept the amount paid by MAD as payment in full, except as otherwise allowed by rule or regulation (42 CFR 447.15).

A. Requirements for reimbursement: A provider is reimbursed for performing a service or procedure only if any required prior authorization, documentation, certifications, or acknowledgements are submitted with the claim and the claim is received by the appropriate claims processing contractor within the filing limits.

B. Electronic billing requirements: Effective December 1, 2008, electronic billing of claims is mandatory unless an exemption has been allowed by MAD. Electronic billing improves the accuracy of claims submission and payment; provides consistency in billing information; and improves the speed of payment. Exemptions will be given on a case by case basis with consideration given to barriers the provider may face in billing electronically, including when volumes are so small that developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply to situations for which paper attachments must accompany the claim form.

C. Responsibility for claims: A provider is responsible for all claims submitted under their national provider identifier (NPI) or other provider number including responsibility for accurate coding that represents the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, and the CMS correct coding initiative.

D. No billing of recipients or third parties: With the exception of WDI and SCHIP or other specified program co-payments or cost-sharing, a provider may not bill, turn over to collection, or accept payment from an eligible recipient, their personal representative or other third parties determined to be legally responsible for the balance of a claim except as specifically allowed by MAD regulations. Following MAD payment, a provider cannot seek additional payment from an eligible recipient or their personal representative in addition to the amount paid by MAD. Following MAD denial of payment due to provider administrative error in filing a claim, a provider cannot seek payment from an eligible recipient or their personal representative or turn the balance over to collection. See 8.302.3 NMAC, *Third Party Liability Provider Responsibilities*.
[8.302.1.15 NMAC - Rp, 8.302.1.15 NMAC, 1/1/2023]

8.302.1.16 ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS: A provider may only bill an eligible recipient or accept payment for services if all of the following requirements are satisfied:

A. The eligible recipient is advised by the provider before services are furnished that a particular service is not covered by MAD or that the particular provider does not accept patients whose medical services are paid for by MAD.

B. The eligible recipient is provided with information by the provider regarding the necessity, options, and charges for the service, and of the option of going to a provider who accepts MAD payment.

C. The eligible recipient still agrees in writing to have specific services provided with the knowledge that he will be financially responsible for payment.
[8.302.1.16 NMAC - Rp, 8.302.1.16 NMAC, 1/1/2023]

8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. (42 CFR 431.107(b)). Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a violation of the Medicaid Provider Act NMSA 1978 Section 27-11-1, et. seq., and a crime punishable under the Medicaid Fraud Act, NMSA, section 30.44-5. See 8.351.2 NMAC, *Sanctions and Remedies*.

A. Detail required in records: Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

(1) When codes, such as the international classification of disease (ICD) or current procedural terminology (CPT), are used as the basis for reimbursement, provider records must be sufficiently detailed to substantiate the codes used on the claim form.

(2) Treatment plans or other plans of care must be

sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

C. Services billed by units of time: Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

D. Recipient funds accounting systems: If an eligible recipient entrusts their personal funds to a nursing facility, intermediate care facility for the intellectually disabled, or swing bed hospital, or any other facility, the facility provider must establish and maintain an acceptable system of accounting. See 42 CFR 445.22.

E. Record retention: A provider who receives payment for treatment, services, or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

(1) treatment or care of any eligible recipient;

(2) services or goods provided to any eligible recipient;

(3) amounts paid by MAD on behalf of any eligible recipient; and

(4) any records required by MAD for the administration of medicaid.

[8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 1/1/2023]

8.302.1.18 PATIENT CONFIDENTIALITY: A provider is required to comply with the HIPAA privacy regulations. Confidential medical information regarding medicaid information on the applicant or eligible recipient must be released by providers to MAD, and to other state or federal agencies, or their employees at no cost when:

A. the agency is involved in the administration of medicaid;

B. the information is to be used to establish eligibility, determine the amount of assistance or provide services related to medicaid;

C. the agency is subject to the same standards of confidentiality as MAD; and

D. the agency has the actual consent of applicant or eligible recipient or their personal representative for release of the information, or consent is obtained when an eligible recipient or their personal representative or a member of the assistance group makes application for benefits or services with the human services department.

[8.302.1.18 NMAC - Rp, 8.302.1.18 NMAC, 1/1/2023]

8.302.1.19 PROVIDER DISCLOSURE: A provider must furnish MAD with the following information. See 42 CFR 431.107(b)(2)(3): name and address of each person with an ownership or controlling interest in the entity or in any subcontractor in which the entity has a direct or indirect ownership interest totaling five percent or more, and any relationship (spouse, child or sibling) of these persons to another; name of any other entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest; name of any person with an ownership or controlling interest in the entity who has been convicted of a criminal offense related to that person's involvement in any program established under the medicare or medical assistance programs; and name of any provider who employs or uses the services of an individual who, at any time during the year preceding this employment, was employed in a managerial, accounting, auditing or similar capacity, by an agency or organization which currently serves or at any time during the preceding year served as a medicare or MAD fiscal intermediary or carrier for the provider. A provider must notify MAD of any change in the status of these disclosure provisions.

A. Reports furnished by providers: A provider must give MAD, the appropriate MAD claims processing contractor, MAD audit contractor, MAD utilization review contractor or MAD designated representative financial reports, audits, certified cost statements, medical and other records, or any other data needed to establish a basis for reimbursement at no cost.

(1) All information regarding any claim for services must be provided. See 42 CFR 431.107(b)(2).

(2) Required cost statements must be furnished no later than 150 calendar days of the close of the provider's fiscal accounting period.

(3) MAD records and other documentation needed by MAD or its designee must be available within a defined period, upon request.

B. Penalties: MAD suspends payment for services until the required statements are furnished by the provider.

C. Conflict of interest: MAD does not enter into a provider participation agreement or other contract with a public officer, employee of the state, legislator, or business in which the individual has a substantial interest, unless the individual discloses their substantial interest and provider participation agreement is accepted by MAD and any other contract is awarded pursuant to the state procurement code Section 10-16-7 NMSA 1978 (Repl. Pamp. 1993).

[8.302.1.19 NMAC - Rp, 8.302.1.19 NMAC, 1/1/2023]

8.302.1.20 TERMINATION OF PROVIDER STATUS:

A. Provider status may be terminated if the provider or MAD gives the other written notice of termination at least 60 calendar days before the effective termination date.

(1) Facility provider must also give at least 15

calendar days notice to the public by publishing a statement of the date services are no longer available at the facility in one or more newspapers of general circulation within the affected county or region.

(2) Normal termination and notice limits do not apply if the state survey agency or health care financing administration determines that the health and safety of residents in a nursing facility or intermediate care facility for the intellectually disabled or the children, youth and families department determines that the health and safety of children or adolescents in a residential treatment center, group home, or treatment foster care are in jeopardy.

B. Grounds for denial or revocation of enrollment: MAD may, with a 30-calendar days notice, deny or terminate a provider's enrollment in its medical assistance program including, but not limited to, medicaid (Title XIX of the Social Security Act) and other health insurance programs funded by the department, if any of the following are found to be applicable to the health care provider, their agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(1) misrepresentation by commission or omission of any information on the MAD provider participation agreement enrollment form;

(2) previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in New Mexico medical assistance programs, any other states medicaid program, medicare, or any other public or private health or health insurance program;

(3) conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under New Mexico medical assistance programs any other states medicaid program, medicare, or any other public or private health or health insurance program;

(4) conviction under federal or state law of a criminal offense relating to the neglect, or abuse of a patient in connection with the delivery of any goods, services, or supplies;

(5) conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(6) conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(7) conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude, or acts against the elderly, children, or infirmed;

(8) conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (3) through (9) of this subsection;

(9) sanction pursuant to a violation of federal or state laws or rules relative to New Mexico medical assistance programs, any other state's medicaid program, medicare, or any other public health care or health insurance program;

(10) violation of licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided;

(11) failure to pay recovery properly assessed or pursuant to an approved repayment schedule under New Mexico medical assistance programs; and

(12) see 8.351.2 NMAC, *Sanctions and Remedies,* and 8.353.2 NMAC, *Provider Hearings*.

[8.302.1.20 NMAC - Rp, 8.302.1.20 NMAC, 1/1/2023]

8.302.1.21 CHANGE IN OWNERSHIP: As soon as possible, but at least 60 calendar days after a change in ownership, MAD reserves the right to withhold payment on all pending or current claims until any right MAD has to recoup portions or all of those payments is determined. Payment will not be withheld if MAD received written confirmation that the new owner or previous medical assistance program provider agrees to be responsible for any potential overpayment.

[8.302.1.21 NMAC - Rp, 8.302.1.21 NMAC, 1/1/2023]

8.302.1.22 PUBLIC DISCLOSURE OF SURVEY INFORMATION: The findings of a MAD survey used to determine the ability of facility provider to begin or continue as medicaid participating provider is available to the public within 90 calendar days of completion.

A. Documents subject to disclosure: Documents subject to public disclosure include:

(1) current survey reports prepared by the survey agency;

(2) official agency notifications of findings based on these reports, including statements of deficiencies;

(3) pertinent parts of written statements furnished by providers to the survey agency related to these reports and findings, including any corrective action taken or planned; and

(4) information regarding the ownership of nursing facility. See 42 CFR 455.104(a).

B. Release of performance reports: Reports on provider's or contractor's performance reviews and formal performance evaluations are not available to the public until the provider or contractor have a reasonable opportunity (not to exceed

30 calendar days) to review the reports and offer comments. These comments become part of the reports.

C. Availability of cost reports: Provider cost reports used as a basis for reimbursement are available to the public upon receipt of a written request by the MAD audit contractor.

(1) Information disclosure is limited to cost report documents required by social security administration regulations, and in the case of a settled cost report, the notice of medicaid settlement.

(2) The request for information must identify the provider and the specific reports requested.

(3) The cost for supplying copies of the cost reports is billed to the requester.
[8.302.1.22 NMAC - Rp, 8.302.1.22 NMAC, 1/1/2023]

HISTORY OF 8.302.1 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records - state records center and archives.
ISD 301.2000, Provider Agreement; 12/21/1979.
ISD 301.2000, Provider Agreement, 12/4/1980.
MAD RULE 301, Procedures and Requirements for Provider Participation, 11/8/1989.
ISD 301.3000, Confidentiality, 12/21/1979.
ISD 301.4000, Public Disclosure of Information, 1/17/1980.
ISD 301.4000, Public Disclosure of Information, 11/24/1980.
SP-004.1300, Section 4, General Program Administration Required Provider Agreement, 3/3/1981.
SP-007.0200, Section 7, General Provisions Nondiscrimination, 3/4/1981.
SP-004.2300, Section 4, General Program Administration Use of Contracts, 3/5/1981.
SP--004.2700, Section 4, General Program Administration Disclosure of Survey Information and Provider or Contractor Evaluation, 3/5/1981.
SP-004.3100, Section 4, General Program Administration Disclosure of Information By Providers and Fiscal Agents, 3/5/1981.
SP-007.0201, Section 7, Nondiscrimination, 6/10/1981.
SP-003.0100, Medical and Remedial Care and Services- Amount, Duration and Scope, 6/18/1981.
SP-003.0100, Section 3, Services: General Revisions - Amount, Duration and Scope of Service, 6/24/1981.

History of Repealed Material:
8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 6/14/2001 Repealed effective 1/1/2023.

Other: : 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 6/14/2001 Replaced by 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies effective 1/1/2023.

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 3 PROFESSIONAL PROVIDERS, SERVICES AND REIMBURSEMENT

8.310.3.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.310.3.1 NMAC - Rp, 8.310.3.1 NMAC, 1/1/2023]

8.310.3.2 SCOPE: The rule applies to the general public.
[8.310.3.2 NMAC - Rp, 8.310.3.2 NMAC, 1/1/2023]

8.310.3.3 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 under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978
[8.310.3.3 NMAC - Rp, 8.310.3.3 NMAC, 1/1/2023]

8.310.3.4 DURATION: Permanent.
[8.310.3.4 NMAC - Rp, 8.310.3.4 NMAC, 1/1/2023]

8.310.3.5 EFFECTIVE DATE: January 1, 2023, unless a later date is cited at the end of a section.
[8.310.3.5 NMAC - Rp, 8.310.3.5 NMAC, 1/1/2023]

8.310.3.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.3.6 NMAC - Rp, 8.310.3.6 NMAC, 1/1/2023]

8.310.3.7 DEFINITIONS: [**RESERVED**]

8.310.3.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.310.3.8 NMAC - Rp, 8.310.3.8 NMAC, 1/1/2023]

8.310.3.9 ELIGIBLE PROVIDERS:

A. Health care to eligible medical assistance program (MAP) recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by the HSD medical assistance division (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 a MAP eligible recipient. 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 MAD New Mexico administrative code (NMAC) program rules, billing instructions, utilization review instructions, and other pertinent materials. 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. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of their MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Upon approval of the New Mexico medical assistance PPA by MAD, the following practitioners and facilities may be enrolled as MAD providers:

(1) medical practitioners:

(a) a physician licensed to practice medicine or osteopathy;

(b) a licensed certified nurse practitioner under the supervision or in collaboration with a physician or as an independent practitioner;

(c) a licensed physician assistant certified by the national commission on certification of physician assistants under the supervision of a physician;

(d) a licensed pharmacist clinician under the supervision of a physician;

(e) a licensed clinical nurse specialist under the supervision or in collaboration with a physician or as an independent practitioner;

(f) a licensed nurse anesthetist certified by the American association of nurse anesthetists council on certification of nurse anesthetists;

(g) a licensed anesthesiologist assistant certified by the national commission for certification of anesthesiologist assistants (NCCAA);

(h) a licensed podiatrist;

(i) a licensed and certified nurse midwife;

(j) a licensed midwife;

(k) a licensed dietician or a licensed nutritionist under the direction of a licensed physician;

(l) a licensed optometrist;

(m) a licensed audiologist certified by the American speech and hearing association;

(n) a licensed chiropractor; or

(o) a licensed naturopathic doctor;

(2) dental practitioners:

(a) a licensed dentist; or

(b) a licensed dental hygienist certified for collaborative practice;

(3) therapists:

(a) a physical therapist licensed by the physical therapy board under the state of New Mexico regulations and licensing division (RLD);

(b) an occupational therapist licensed by the board of occupational therapy under RLD; or

(c) a speech pathologist licensed by the board of speech, language, hearing under RLD;

(4) clinical laboratory, radiology, and diagnostic facilities:

(a) an independent clinical laboratory having a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration applicable to the category of procedures performed by the laboratory;

(b) a licensed radiological facility; or

(c) a licensed diagnostic laboratory;

(5) transplant centers: practitioners and facilities licensed or certified to furnish specialized transplant medical or surgical services;

(6) other providers described in other rules found in NMAC rules eligible to provide services or receive reimbursement, such as behavioral health services, early and periodic screening, diagnostic and treatment (EPDST) services, institutional services, and other specialized services.

B. Upon approval of the New Mexico MAD PPA agreement by MAD or its designee, the clinic, professional association, or other legal entity may be enrolled as a MAD provider in order that payment may be made to the clinic, professional association, or other legal entity formed by one or more individual practitioners. The individual practitioners that are employed by or contracted by the clinic, professional practice or other legal entity must also be enrolled as individual providers. All requirements under state law and regulations or rules regarding supervision, direction, and approved supervisory practitioners must be met. Such entities include:

(1) professional components for inpatient and outpatient institutions;

(2) professional corporations and other legal entities;

(3) licensed diagnostic and treatment centers, including a birthing center licensed as a diagnostic and treatment center;

(4) licensed family planning clinics;

(5) public health clinics or agencies;

(6) Indian health services (IHS) facilities; and

(7) PL.93-638 tribal 638 facilities.

C. All services rendered must be within the legal scope of practice of the practitioner or provider and are limited to benefits and services covered by MAD including meeting requirements for medical necessity.

D. All providers must be licensed in New Mexico for services performed in New Mexico. For services performed by providers outside of New Mexico, a provider's out of state license may be accepted in lieu of licensure in New Mexico if the out of state licensure requirements are similar to those of the state of New Mexico. For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

E. Additional licensure or certification requirements may be required for specialized services such as services provided to MAP special needs recipients. Transplantation providers are eligible for enrollment if licensed as state transplantation centers by the licensing and certification bureau of the New Mexico department of health (DOH); or if certified as transplantation centers by the centers for medicare and medicaid services (CMS).

F. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and NMAC rules or meet federal requirements for providing services to IHS facilities or tribal contract facilities.

[8.310.3.9 NMAC - Rp, 8.310.3.9 NMAC, 1/1/2023]

8.310.3.10 COVERED SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of NMAC rules and benefits and within the scope and practice of the provider's professional standards.

[8.310.3.10 NMAC - Rp, 8.310.3.10 NMAC, 1/1/2023]

8.310.3.11 REIMBURSEMENT: Providers must submit claims for reimbursement on the CMS-1500, American dental association (ADA), or universal billing (UB) claim form or their successor or their electronic equivalents, as appropriate to the provider type and service.

A. A provider is responsible for following coding manual guidelines and CMS national correct coding initiatives, including not improperly unbundling or upcoding services, not reporting services together inappropriately, and not reporting an inappropriate number or quantity of the same service on a single day. Bilateral procedures and incidental procedure are also subject to special billing payment policies. The payment for some services includes payment for other services. For example, payment for a surgical procedure may include hospital visits and follow up care or supplies which are not paid separately.

B. General reimbursement:

(1) reimbursement to professional service providers is made at the lesser of the following:

(a) the provider's billed charge; or

(b) the MAD fee schedule for the specific service or procedure;

(2) the billed charge must be the provider's usual and customary charge for the service or procedure.

(3) "usual and customary" charge refers to the amount that the provider charges the general public in the majority of cases for a specific procedure or service.

C. Reimbursement limitations:

(1) Nurses: Reimbursement to CNPs and CNSs who are in independent practice are limited to 90 percent of the MAD fee schedule amount allowed for physicians providing the same service.

(2) Midwife services: Reimbursement for a certified nurse midwife or a licensed midwife for maternity services is based on one global fee which includes prenatal care, delivery, postnatal and postpartum care. Services related to false labor are included as part of the global fee. Certified nurse midwives are reimbursed at the rate paid to physicians for furnishing similar services. Licensed midwives are reimbursed at seventy-seven percent of the rate paid to physicians for furnishing the global services and at one hundred percent of the rate paid to physicians for add-on services. Other services are paid according to the MAD fee schedule.

(3) Surgery: Surgical assistants are reimbursed at twenty percent of the allowed primary surgeon amount. Surgical assistants are paid only when the surgical code allows for assistants as determined by medicare, CMS, or MAD. Physician assistants (PA), pharmacist clinicians, CNP's, midwives, and CNS's can only be paid as surgical assistants when it is within the scope of their practice as determined by state statute and their licensing boards.

(4) Physician extenders: Physician assistants, pharmacist clinicians and other providers not licensed for independent practice are not paid directly. Reimbursement is made to the supervising provider or entity under which the extender works.

(5) Hospital settings: Reimbursement for services provided in hospital settings that are ordinarily furnished in a provider's office is made at sixty percent of the fee schedule allowed amount. MAD follows medicare principles in determining which procedures and places of service are subject to this payment reduction. For services not covered by medicare, the determination is made by MAD. For facility-based providers, costs

billed separately as a professional component must be identified for exclusion from the facility cost report prior to cost settlement or rebasing.

(6) Dietician and nutrition services: For nutritional counseling services, physicians, physician extenders and clinics must include the charges for nutritional services in the office visit code when services are furnished by physicians or physician extenders. The level of the office visit reflects the length and complexity of the visit. For services furnished as part of prenatal or postpartum care, nutritional counseling services are included in the reimbursement fees for prenatal and postpartum care and are not reimbursed separately. Nutritional assessment and counseling services can be billed as a separate charge only when services are furnished to a MAP eligible recipient under age 21 by licensed nutritionists or licensed dieticians who are employed by eligible providers. Reimbursement is made to eligible providers and not directly to the nutritionists or dieticians.

(7) Laboratory and diagnostic imaging reimbursement limitations:

(a) Use of medicare maximums: The MAD payment does not exceed the amount allowed by medicare for any laboratory service. Medicare notifies MAD on an annual basis of its fee schedule for clinical laboratory services. These new fees become the maximums for reimbursement upon implementation by MAD.

(b) Referrals from providers: Physicians and other private practitioners cannot bill for laboratory tests which are sent to an outside laboratory or other facility. Payment for laboratory services cannot be made directly to a practitioner unless the tests were performed in their own office. Laboratories can bill for tests sent to other laboratories only if the CLIA number of the other laboratory is identified on the claim form. State facilities which contract for services with other state-operated laboratories, such as the state health laboratory, can bill for those services providing the amount billed for the service does not exceed the amount paid by the state facility to the contractor.

(c) Reimbursement for collection costs: MAD does not reimburse an independent clinical laboratory separately for associated collection costs such as office visits, home visits or nursing home visits.

(d) Services performed as profile or panel: Individual lab procedures that are routinely considered to be included in a profile or panel must be billed as a panel. MAD cannot be billed for individual lab procedures that are considered included in a profile or panel.

(8) Radiology:

(a) Non-profit licensed diagnostic and treatment centers and state facilities: Non-profit licensed diagnostic and treatment centers which contract for radiological services can bill for services provided that the charge does not exceed the amount paid to the contractor by the licensed diagnostic and treatment center.

(b) Reimbursement for additional charges: Reimbursement for performance of a radiology procedure is considered paid in full when payment is made for the procedure. Additional services such as office visits, home visits, and nursing home visits are not reimbursed separately.

(c) Reimbursement for inclusive procedures: Reimbursement for certain radiological procedures is included in the reimbursement for other procedures. Reimbursement for the lesser procedure is always considered to be included in the payment for the more comprehensive procedure for a specified group.

(d) Reimbursement for the professional component of a radiology service does not exceed forty percent of the amount allowed for the complete procedure.

(i) A professional component or interpretation is not payable to the same provider who bills for the complete procedure.

(ii) A claim for "supervision and interpretation only" is not payable in addition to a claim for the complete procedure.

(9) Telemedicine providers: Reimbursement for services at the originating-site (where the MAP eligible recipient is located) and the distant-site (where the provider is located) are made at the same amount as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for an interactive telemedicine system fee at the lesser of the provider's billed charge; or the maximum allowed by MAD for the specific service or procedure.

D. Reimbursement for services furnished by medical interns or residents: Reimbursement for services furnished by an intern or a resident in a hospital with an approved teaching program or services furnished in another hospital that participates in a teaching program is only made through an institutional reimbursement process. Medical or surgical services performed by an intern or a resident that are unrelated to educational services, internship, or residency, are reimbursed according to the MAD fee schedule for physician services when all of the following provisions are met:

(1) services are identifiable physician services that are performed by the physician in person;

(2) services must contribute to the diagnosis or treatment of the MAP eligible recipient's medical condition;

(3) an intern or resident is fully licensed as a physician;

(4) services are performed under the terms of a written contract or agreement and are separately identified from services required as part of the training program; and

(5) services are excluded from outpatient hospital costs; when these criteria are met the services are considered to have been furnished by the practitioner in their capacity as a physician and not as an intern or resident.

E. Services of an assistant surgeon in an approved teaching program:

(1) MAD does not pay for the services of an assistant surgeon in a facility with approved teaching program since the resident is available to perform services unless the following exceptional medical circumstances exist:

(a) an assistant surgeon is needed due to unusual medical circumstances;

(b) the surgery is performed by a team of physicians during a complex procedure; or

(c) the presence of, and active care by, a physician of another specialty is necessary during the surgery due to the MAP eligible recipient's medical condition.

(2) This reimbursement rule may not be circumvented by private contractors or agreements entered into by a hospital with a physician or a physician group.

F. Reimbursement for dental residents: Reimbursement can be made for dental residents in an approved teaching program when all the following conditions are met:

(1) the resident is fully licensed as a dentist for independent practice;

(2) the costs of the dental residency program is not included in the direct or graduate medical education payments to a provider operating the teaching program; and

(3) only one dental claim is submitted for the service; the supervising dentist and the rendering dentist will not be both paid for the service or procedure.

G. Non-independent practitioners: Reimbursement for services furnished by a physician assistant, a pharmacist clinician, or another practitioner whose license is not for independent practice, is made only to the billing supervising practitioner or entity rather than directly to the supervised practitioner.

H. Surgical procedures: Reimbursement for surgical procedures is subject to certain restrictions and limitations.

(1) When multiple procedures that add significant time or complexity to care are furnished during the same operative session, the major procedure is reimbursed at one hundred percent of the allowable amount, the secondary procedure is reimbursed at fifty percent of the allowable amount and any remaining procedures are reimbursed at twenty-five percent of the allowable amount. Multiple procedures occurring in one incision are reimbursed similarly. "Multiple surgery" is defined as multiple surgical procedures billed by the same physician for the same MAP eligible recipient on the same date of service.

(2) Bilateral procedures that are furnished in the same operative session are billed as one service with a modifier. Reimbursement for bilateral procedures is one hundred fifty percent of the amount allowed for a unilateral procedure.

(3) Surgeons are not reimbursed for the performance of incidental procedures, such as incidental appendectomies, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernias, or tubal ligations done in conjunction with cesarean sections.

(4) Providers are not reimbursed for performing complete physical examinations or histories during follow-up treatment after a surgical procedure.

(5) Other health care related to a surgery is considered to be reimbursed in the payment for the surgery and is not paid as a separate cost. Surgical trays and local anesthesia are included in the reimbursement for the surgical procedure.

(6) Under certain circumstances, the skills of two surgeons, usually with different surgical specialties may be required in the management of a specific surgical problem. The total allowed value of the procedure is increased by twenty-five percent and each surgeon is paid fifty percent of that amount.

I. Maternity services: Reimbursement for maternity care is based on one global fee. Routine prenatal, delivery postnatal and postpartum care are included in the global fee. Services related to false labor and induced labor are also included in the global fee.

(1) If partial services are furnished by multiple providers, such as prenatal care only, one or two trimesters of care only, or delivery only, the procedure codes billed must reflect the actual services performed. The date of services must be the last day services were furnished for that specific procedure code.

(2) MAD pays based on a modifier for high-risk pregnancies or for complicated pregnancies. The determination of high risk is based on a claims review.

(3) If partial services are furnished by a certified nurse midwife or licensed midwife, such as prenatal care only, one or two trimesters of care only or delivery only, the procedure codes billed must reflect the actual services performed. The date of service must be the last day services were furnished for that specific code.

(4) If the services furnished include a combination of services performed by a certified nurse midwife or licensed midwife, and a physician in the same group practice, reimbursement for midwife services is based on trimesters of service furnished by the certified nurse midwife or licensed midwife.

(5) MAD pays supply fees only when a MAP eligible recipient is accommodated for two hours or more in the home or a birthing center prior to delivery. Payment for use of a licensed birthing center includes supplies.

(6) MAD covers postnatal and postpartum care by a certified nurse midwife or licensed midwife, as a separate service only when the midwife does not perform the delivery.

(7) Reimbursement for a single vaginal delivery assist is allowed when the assist service is furnished by licensed or certified midwives who are MAD providers. The need for the assistance based on the medical condition of the MAP eligible recipient must be documented.

(8) Reimbursement for cesarean sections and inductions is made only when the service is medically necessary. These services are not covered as elective procedures.

(9) MAD covers laboratory and diagnostic imaging services related to an essentially normal pregnancy. These services can be billed separately.

(10) Non/ covered midwife services: Midwife services are subject to the limitation and coverage restrictions which exist for other MAD services. MAD does not cover the following specific services furnished by a midwife:

(a) oral medications or medications, such as ointments, creams, suppositories, ophthalmic and otic preparations which can be appropriately self/ administered by the MAP eligible recipient;

(b) services furnished by an apprentice, unless billed by the supervising midwife;

(c) an assistant at a home birth unless necessary based on the medical condition of the MAP eligible recipient which must be documented in the claim.

(11) Birthing options program (BOP): The BOP is specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

(a) The BOP out-of-hospital birth locations include a pregnant member's home or a licensed birth center.

(b) A BOP participant may elect to have a home birth or birth in a licensed birth center when she has BOP services provided by an eligible midwife that enrolls as a BOP provider with the Human Services Department/medical assistance division (HSD/MAD) and the New Mexico Department of Health/maternal health division (NMDOH/MHC).

J. Services limited by frequency:

(1) services furnished by another provider: where coverage of services provided to MAP eligible recipient is restricted or limited by frequency of services, procedures or materials, it is a provider's responsibility to determine if a proposed service has already been furnished by another provider, such that the MAP eligible recipient has exhausted the benefit. Examples include but are not limited to dental services, vision exams and eyeglasses.

(2) direct MAP eligible recipient payment for services: a provider can make arrangements for direct payment from a MAP eligible recipient or their authorized representative for noncovered services. A MAP eligible recipient or their authorized representative can only be billed for noncovered services if:

(a) a MAP eligible recipient or their authorized representative is advised by a provider of the necessity of the service and the reasons for the non-covered status;

(b) a MAP eligible recipient or their authorized representative is given options to seek treatment at a later date or from a different provider;

(c) a MAP eligible recipient or their authorized representative agrees in writing to be responsible for payment; and

(d) the provider fully complies with the NMAC rules relating to billing and claims filing limitations.

(3) services considered part of the total treatment: a provider cannot bill separately for the services considered included in the payment for the examination, another service, or for routine post-operative or follow-up care.

K. Anesthesia services:

(1) Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia "base units" plus units for time.

(a) Each anesthesia procedure is assigned a specific number of relative value units which becomes the "base unit" for the procedure. Units of time are also allowed for the procedure. Reimbursement is calculated by multiplying the total number of units by the conversion factor allowed for each unit.

(b) The reimbursement per anesthesia unit may vary depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically-directed certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA) and a non-directed CRNA.

(c) For anesthesia provided directly by a physician anesthesiologist, CRNA, or an anesthesiologist assistant, one time unit is allowed for each 15-minute period a MAP eligible recipient is under anesthesia. For medical direction, one time unit is allowed for each 15-minute period.

(2) Medical direction: Reimbursement is made at fifty percent of the full anesthesia service amount for medical direction by a physician anesthesiologist who is not the surgeon or assistant surgeon, for directing an anesthesiology resident, a registered nurse anesthetist (CRNA) or an anesthesiologist assistant (AA). Reimbursement is made at fifty

percent of the full anesthesia service amount for the anesthesia service provided by the medically directed anesthesiology resident, CRNA or AA. Medical direction occurs if the physician medically directs qualified practitioners in two, three, or four concurrent cases and the physician performs the activities described below. Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a MAP eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-MAP eligible recipients and the remaining is a MAP eligible recipient, this represents three concurrent cases.

(a) Time units for medical direction are allowed at one time unit for each 15-minute interval.

(b) Anesthesia claims are not payable if the surgery is not a MAD benefit or if any required documentation was not obtained.

(c) Medical direction is a covered service only if the physician:

(i) performs a pre-anesthesia examination and evaluation; and

(ii) prescribes the anesthesia plan; and

(iii) personally participates in the most demanding procedures of the anesthesia plan including induction and emergence; and

(iv) ensures that any procedures in the anesthesia plan that they do not perform are performed by a qualified anesthetist; and

(v) monitors the course of anesthesia administration at frequent intervals; and

(vi) remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) provides indicated post-anesthesia care.

(d) For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

(e) A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients may not ordinarily be involved in furnishing additional services to other patients. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. Medical direction criteria are met even though the physician responds to an emergency of short duration.

(f) While directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

(g) If a physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patient, the physician's services to the surgical patients are supervisory in nature. Medical direction cannot be billed.

(3) Monitored anesthesia care: Medically necessary monitored anesthesia care (MAC) services are reimbursed at base units plus time units.

(a) "Monitored anesthesia care" is anesthesia care that involves the intraoperative monitoring by a physician or qualified practitioner under the medical direction of a physician, or of the MAP eligible recipient's vital physiological signs in anticipation of the need for administration of general anesthesia, or of the development of adverse physiological MAP eligible recipient reaction to the surgical procedure and includes:

(i) performance of a pre-anesthetic examination and evaluation;

(ii) prescription of the anesthesia care required;

(iii) continuous intraoperative monitoring by a physician anesthesiologist or qualified certified registered nurse anesthetist of the MAP eligible recipient's physiological signs;

(iv) administration of medication or other pharmacologic therapy as can be required for the diagnosis and treatment of emergencies; and

(v) provision of indicated postoperative anesthesia care.

(b) For MAC, documentation must be available to reflect pre- and post-anesthetic evaluations and intraoperative monitoring.

(c) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

(4) Medical supervision: If an anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised rather than medically directed anesthesia services. The MAD payment to the CRNA will be fifty percent of the MAD allowable amount for the procedure. Payment to the anesthesiologist will be based on three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing

other services while directing the concurrent procedure.

(5) Obstetric anesthesia: Reimbursement for neuraxial labor anesthesia is paid using the base units plus one unit per hour for neuraxial analgesia management including direct patient contact time (insertion, management of adverse events, delivery, and removal).

(6) Unusual circumstances: When it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. Documentation supporting the medical necessity for both must be noted in the MAP eligible recipient's record.

(7) Pre-anesthetic exams and cancelled surgery: A pre-anesthetic examination and evaluation of a MAP eligible recipient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service.

(8) Performance of standard procedures: If an anesthesiologist performs procedures which are generally performed by other physicians without specific anesthesia training, such as local anesthesia or an injection, the anesthesiologist is reimbursed the fee schedule amount for performance of the procedure. Reimbursement is not made for base units or units for time.

(9) Add-on codes for anesthesia: Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are paid in addition to the primary anesthesia code. Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit of the add-on code will be allowed. All anesthesia time must be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia. MAD requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

(10) Anesthesia services furnished by the same physician providing the medical and surgical service:

(a) A physician who both performs and provides moderate sedation for medical or surgical services will be paid for the conscious sedation consistent with CPT guidelines; however, a physician who performs and provides local or minimal sedation for these procedures cannot bill and cannot be paid separately for the sedation services. The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

(i) local or topical anesthesia; to

(ii) moderate (conscious) sedation; to

(iii) regional anesthesia; to

(iv) general anesthesia.

(b) Moderate sedation is a drug-induced depression of consciousness during which a MAP eligible recipient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care. If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines. However, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

[8.310.3.11 NMAC - Rp, 8.310.3.11 NMAC, 1/1/2023]

HISTORY OF 8.310.3 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 310.0100, Physician Services, filed 1/9/1980.
ISD 310.0100, Physician Services, filed 6/16/1980.
ISD 310.0100, Physician Services, filed 4/2/1982.
ISD-Rule-310.0100, Physician Services, filed 9/2/1983.
ISD-Rule-310.0100, Physician Services, filed 3/30/1984.
ISD Rule-310.0100, Physician Services, filed 4/26/1984.
ISD Rule-310.0100, Physician Services, filed 2/25/1986.
MAD Rule 310.01, Physician Services, filed 12/15/1987.
MAD Rule 310.01, Physician Services, filed 4/27/1988.
MAD Rule 310.01, Physician Services, filed 4/20/1992.
MAD Rule 310.01, Physician Services, filed 3/10/1994.
MAD Rule 310.27, Anesthesia Services, filed 7/2/1990.

History of Repealed Material:

MAD Rule 310.01, Physician Services, filed 3/10/1994 - Repealed effective 2/1/1995.
MAD Rule 310.27, Anesthesia Services, filed 7/2/1990 - Repealed effective 2/1/1995.
8.310.2 NMAC, Medical Services Providers, filed 2/16/2004 - Repealed effective 1/1/2014.
8.310.3 NMAC, Rural Health Clinic Services, filed 2/7/2012 - Repealed effective 1/1/2014. Replaced by 8.310.9 NMAC, Rural Health Clinic Services, effective 1/1/2014.
8.310.5 NMAC, Anesthesia Services, filed 5/12/2003 - Repealed effective 1/1/2014.
8.310.13 NMAC, Telehealth Services, filed 7/17/2007 - Repealed 1/1/2014.
8.324.2 NMAC, Laboratory Services, filed 2/7/2012 - Repealed 1/1/2014.
8.324.3 NMAC, Diagnostic Imaging and Therapeutic Radiology Services, filed 2/7/2012 - Repealed 1/1/2014.
8.324.9 NMAC, Nutrition Services, filed 2/7/2012 - Repealed 1/1/2014.
8.325.3 NMAC, Reproductive Services, filed 1/18/1995 - Repealed 1/1/2014.

8.310.3 NMAC, Professional Providers, Services And Reimbursement filed 12/17/2013 - Repealed 1/1/2023.

Other History: 8.310.3 NMAC, Professional Providers, Services And Reimbursement filed 12/17/2013, Replaced by 8.310.3 NMAC, Professional Providers, Services And Reimbursement effective 1/1/2023.

PUBLIC REGULATION COMMISSION

The New Mexico Public Regulation Commission, approved at its 12/7/2022 open meeting, to repeal its rule 17 NMAC 3.510 - Uniform Systems Of Accounts And Annual Report Forms For Electric Utilities (filed 6/30/1988) and replace it with 17.3.510 NMAC - Uniform Systems Of Accounts And Annual Report Forms For Electric Utilities, effective 12/27/2022.

The New Mexico Public Regulation Commission, approved at its 12/7/2022 open meeting, to repeal its rule 17 NMAC 3.610 - Uniform Systems Of Accounts And Annual Report Forms (filed 6/30/1988) and replace it with 17.3.610 NMAC - Uniform Systems Of Accounts And Annual Report Forms, effective 12/27/2022.

The New Mexico Public Regulation Commission, approved at its 11/18/2022 open meeting, to repeal its rule 17.5.440 NMAC - Extensions, Improvements, Additions, And Cooperative Agreements Between Or Among Utilities (filed 5/1/2013) and replace it with 17.5.440 NMAC - Extensions, System Improvements, Repairs Or Replacements, Additions, And Cooperative Agreements Between Or Among Utilities, effective 12/27/2022.

PUBLIC REGULATION COMMISSION

TITLE 17 PUBLIC UTILITIES AND UTILITY SERVICES
CHAPTER 3 UTILITIES FINANCIAL ACCOUNTING AND REPORTING - GENERAL PROVISIONS
PART 510 UNIFORM SYSTEMS OF ACCOUNTS AND ANNUAL REPORT FORMS FOR ELECTRIC UTILITIES

17.3.510.1 ISSUING AGENCY: New Mexico Public Regulation Commission.
[17.3.510.1 NMAC - Rp, 17 NMAC 3.510.1, 12/27/2022]

17.3.510.2 SCOPE: [RESERVED]
[17.3.510.2 NMAC - Rp, 17 NMAC 3.510.2, 12/27/2022]

17.3.510.3 STATUTORY AUTHORITY: Sections 8-8-4 and 8-8-15 NMSA1978 of the Public Regulation Commission Act; and Sections 61-8-1 to 62-8-13 NMSA 1978, Duties and Restrictions Imposed Upon Public Utilities.
[17.3.510.3 NMAC - Rp, 17 NMAC 3.510.3, 12/27/2022]

17.3.510.4 DURATION: Permanent.
[17.3.510.4 NMAC - Rp, 17 NMAC 3.510.4, 12/27/2022]

17.3.510.5 EFFECTIVE DATE: December 27, 2022 unless a later date is cited at the end of a section.
[17.3.510.5 NMAC - Rp, 17 NMAC 3.510.5, 12/27/2022]

17.3.510.6 OBJECTIVE: [RESERVED]
[17.3.510.6 NMAC - Rp, 17 NMAC 3.510.6, 12/27/2022]

17.3.510.7 DEFINITIONS: [RESERVED]
[17.3.510.7 NMAC - Rp, 17 NMAC 3.510.7, 12/27/2022]

17.3.510.8 TABLE OF CONTENTS:

[17.3.510.8 NMAC - Rp, 17 NMAC 3.510.8, 12/27/2022]

17.3.510.9 CLASSIFICATION OF ELECTRIC UTILITIES: Investor-owned electric public utilities shall be and are hereby classified in accordance with their annual operating revenues as follows:

CLASS	ANNUAL OPERATING REVENUES OF
A	$2,500,000 or more.
B	$1,000,000 or more, but less than $2,500,000.
C	$150,000 or more, but less than $1,000,000.
D	$25,000 or more, but less than $150,000.
E	less than $25,000.

[17.3.510.9 NMAC - Rp, 17 NMAC 3.510.9, 12/27/2022]

17.3.510.10 UNIFORM SYSTEMS OF ACCOUNTS AND ANNUAL REPORT FORMS:

A. Class A and class B electric utilities as defined in 17.3.510.9 NMAC shall keep their books and records in compliance with the uniform system of accounts for public utilities and licensees (class A and class B), effective April 1, 1973, prescribed by the FPC with subsequent revisions prescribed by FERC, and shall use the current form of annual report for electric utilities and licensees (class A and class B) prescribed by FERC.

B. Class C electric utilities as defined in 17.3.510.9 NMAC shall keep their books and records in compliance with the uniform system of accounts for public utilities and licensees (class C), effective April 1, 1973, prescribed by the FPC with subsequent revisions prescribed by FERC, and shall use the current form of annual report for public utilities and licensees (class C and class D), prescribed by FERC.

C. Class D and class E electric utilities as defined in 17.3.510.9 NMAC shall keep their books and records in compliance with the uniform system of accounts for public utilities and licensees (class D) effective April 1, 1973, prescribed by the FPC with subsequent revisions prescribed by FERC, and shall use the current form of annual report for public utilities and licensees (class C and class D) prescribed by the FERC.

D. Rural electric cooperatives shall keep their books and records in compliance with the uniform system of accounts prescribed for electric borrowers of the rural electrification administration, REA bulletin 181-1. The form of rural electric cooperatives' annual report to the New Mexico public regulation commission shall be in the form provided by the commission. Rural electric cooperatives having an annual electric operating revenues and patrons' capital of $150,000 or less for business transacted in the state of New Mexico shall have the option of filing FERC form No. 1 for electric utilities and licensees (class A and class B) as prescribed above, or they may file one copy each of REA form no. 7 and REA form no. 40 covering their New Mexico operations, and one copy each of REA form no. 7 and REA form no. 40 covering their total operations. A rural electric cooperative's reports shall reflect the operations for the year ending December 31.

[17.3.510.10 NMAC - Rp, 17 NMAC 3.510.10, 12/27/2022]

17.3.510.11 EFFECT OF ADOPTION OF UNIFORM SYSTEMS OF ACCOUNTS: The adoption of the respective uniform systems of accounts by 17.3.510.10 NMAC shall not be construed as approval or acceptance of any item recorded pursuant to the said system of accounts on the books of any utility for the purpose of fixing rates or determining other matters before the commission. The uniform system of accounts is designed to record the facts of the operations of all electric utilities in a uniform manner, and when engaged in fixing rates or passing upon other matters before it the commission will determine what consideration shall be given to various items so recorded in the several accounts.

[17.3.510.11 NMAC - Rp, 17 NMAC 3.510.11, 12/27/2022]

17.3.510.12 ANNUAL REPORTING:

A. Each utility affected by 17.3.510 NMAC shall report to the commission annually for each calendar year not later than April 30 of the following year upon forms provided by the commission. Attached to this report shall be the company's most recently filed SEC form 10K, if applicable, 17.3.510 NMAC Form 1 regarding jurisdictional customer numbers, and the company's most recent load growth forecast, if such is prepared routinely by the company. Each utility shall retain one copy of the report in its files. If additional time beyond April 30 is required by any utility it shall request in writing such additional time as may be needed, and the commission in the exercise of its discretion may grant such additional time as it believes is reasonable and necessary.

B. Each utility affected by 17.3.510 NMAC which has not had a general rate case decided by a final order of the commission after a hearing on the merits of an unstipulated general rate case during the previous four year period prior to the filing of its annual report shall:

(1) for the company's total electric utility operations, and the company's New Mexico jurisdictional electric utility operations file, using actual unadjusted numbers, for both the current year and the figures approved by the commission in the company's last general rate case the following information:

(a) revenues;

(b) earnings;

(c) return on equity (or margin);

(d) amount of debt and average cost of debt;

(e) capital structure;

(f) generation plant-in-service, including for each plant;

(i) installed cost (including capital additions);

(ii) in-service date;

(iii) plant type (steam, combustion turbine, nuclear, etc.); and

(iv) fuel source(s);

(g) transmission and sub-transmission plant-in-service;

(h) distribution plant-in-service;

(i) operation and maintenance expense (with fuel and purchased power, and nuclear and non-nuclear O&M shown separately);

(j) deferred tax reserves;

(k) peak demand; and

(l) net energy sales (kWh);

(2) provide in detail the derivation of each number set forth above from actual measured numbers, including an explanation of the jurisdictional allocations used; and

(3) identify and explain any adjustment, factor or extraordinary item which the company believes would materially affect its return on equity as reflected above or prospectively.

C. Each utility affected by 17.3.510 NMAC shall provide a detailed report annually for each calendar year not later than April 30 of the following year setting forth and listing its compliance or failure to comply with each part of the commission's final order in each of the cases decided that the utility has a requirement of compliance ordered during the preceding five years or since the utility's last general rate case order, whichever period is longer.

D. The staff of the utility division will review the annual reports for compliance and will, in writing, request additional information from the utility if required. Staff will summarize the annual reports and the division director of the utility division will provide a written report to the commission on or before July 1 of the report year.

[17.3.510.12 NMAC - Rp, 17 NMAC 3.510.12, 12/27/2022]

17.3.510.13 QUARTERLY REPORTING: Any utility required to file SEC form 10Q and which is affected by 17.3.510 NMAC, shall file one copy of its completed SEC form 10Q with the commission at the same time the utility files this form with the SEC. Each utility shall retain one copy of the form 10Q in its files.

[17.3.510.13 NMAC - Rp, 17 NMAC 3.510.13, 12/27/2022]

HISTORY OF 17.3.510 NMAC: Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records-State Records Center and Archives.

Second Amended General Order No. 21, Regulations Governing Annual Report Filings for Electric Utilities, filed 5/4/1983 NMPSC Rule 510, Uniform Systems of Accounts and Annual Report Forms for Electric Utilities, filed 6/30/1988.

History of Repealed Material: 17 NMAC 3 510**,** Uniform Systems Of Accounts And Annual Report Forms For Electric Utilities filed (6/30/1988) effective 12/27/2022.

Other: 17 NMAC 3 510**,** Uniform Systems Of Accounts And Annual Report Forms For Electric Utilities filed (6/30/1988) replaced by 17.3.510 NMAC, Uniform Systems Of Accounts And Annual Report Forms For Electric Utilities effective 12/27/2022.

PUBLIC REGULATION COMMISSION

TITLE 17 PUBLIC UTILITIES AND UTILITY SERVICES
CHAPTER 3 UTILITIES FINANCIAL ACCOUNTING AND REPORTING-GENERAL PROVISIONS
PART 610 UNIFORM SYSTEMS OF ACCOUNTS AND ANNUAL REPORT FORMS

17.3.610.1 ISSUING AGENCY: New Mexico Public Regulation Commission.

[17.3.610.1 NMAC - Rp, 17 NMAC 3.610.1 NMAC, 12/27/2022]

17.3.610.2 SCOPE: [RESERVED]

[17.3.610.2 NMAC - Rp, 17 NMAC 3.610.2 NMAC, 12/27/2022]

17.3.610.3 STATUTORY AUTHORITY: Sections 8-8-4 and 8-8-15 NMSA1978 of the Public Regulation Commission Act; and Sections 61-8-1 to 62-8-13 NMSA 1978, Duties and Restrictions Imposed Upon Public Utilities.

[17.3.610.3 NMAC - Rp, 17.3.610.3 NMAC, 12/27/2022]

17.3.610.4 DURATION: Permanent.

[17.3.610.4 NMAC - Rp, 17 NMAC 3.610.4 NMAC, 12/27/2022]

17.3.610.5 EFFECTIVE DATE: December 27, 2022 unless a later date is cited at the end of a section.

[17.3.610.5 NMAC - Rp, 17 NMAC 3.610.5 NMAC, 12/27/2022]

17.3.610.6 OBJECTIVE: [RESERVED]

[17.3.610.6 NMAC - Rp, 17 NMAC 3.610.6 NMAC, 12/27/2022]

17.3.610.7 DEFINITIONS: [RESERVED]

[17.3.610.7 NMAC - Rp, 17 NMAC 3.610.7 NMAC, 12/27/2022]

17.3.610.8 TABLE OF CONTENTS:

A. Classification of gas utilities - 17.3.610.9 NMAC.

B. Uniform system of accounts and annual report forms for class A and class B utilities - 17.3.610.10 NMAC.

C. Uniform system of accounts and annual report forms for class C utilities - 17.3.610.11 NMAC.

D. Uniform system of accounts and annual report forms for class D and class E utilities - 17.3.610.12 NMAC.

E. Effect of adoption of uniform systems of accounts - 17.3.610.13 NMAC.

F. Annual reporting - 17.3.610.14 NMAC.

[17.3.610.8 NMAC - Rp, 17 NMAC 3.610.8 NMAC, 12/27/2022]

17.3.610.9 CLASSIFICATION OF GAS UTILITIES: Gas public utilities are classified in accordance with their annual operating revenues as follows:

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CLASS	ANNUAL OPERATING REVENUES OF
A	$2,500,000 or more.
B	$1,000,000 or more, but less than $2,500,000.
C	$150,000 or more, but less than $1,000,000.
D	$25,000 or more, but less than $150,000.
E	less than $25,000.

[17.3.610.9 NMAC - Rp, 17 NMAC 3.610.9 NMAC, 12/27/2022]

17.3.610.10 UNIFORM SYSTEM OF ACCOUNTS AND ANNUAL REPORT FORMS FOR CLASS A AND CLASS B UTILITIES: Class A and class B gas public utilities as defined in 17.3.610.9 NMAC shall keep their books and records in compliance with the uniform system of accounts for natural gas companies (class A and class B), effective January 1, 1961, prescribed by the FPC with subsequent revisions by FERC, and shall use the current form of annual report for natural gas companies (class A and class B) prescribed by FERC; provided that any class A or class B gas public utility may at its option keep its books and records in compliance with the uniform system of accounts for class A and class B gas utilities, 1958, adopted by NARUC at its annual convention in 1958.
[17.3.610.10 NMAC - Rp, 17 NMAC 3.610.10 NMAC, 12/27/2022]

17.3.610.11 UNIFORM SYSTEM OF ACCOUNTS AND ANNUAL REPORT FORMS FOR CLASS C UTILITIES: Class C and class D gas public utilities as defined in 17.3.610.9 NMAC shall keep their books and records in compliance with the uniform system of accounts for natural gas companies (class C), effective January 1, 1961, prescribed by the FPC with subsequent revisions by FERC, and shall use the current form of annual report for natural gas companies (classes C and D) prescribed by FERC; provided that any class C gas public utility may at its option keep its books and records in compliance with the uniform system of accounts for class C gas utilities, 1958, adopted by NARUC at its annual convention in 1958.
[17.3.610.11 NMAC - Rp, 17 NMAC 3.610.11 NMAC, 12/27/2022]

17.3.610.12 UNIFORM SYSTEM OF ACCOUNTS AND ANNUAL REPORT FORMS FOR CLASS D AND CLASS E UTILITIES: Class D and class E gas public utilities as defined in 17.3.610.9 NMAC shall keep their books and records in compliance with the uniform system of accounts for natural gas companies (class D), effective January 1, 1961, prescribed by the FPC with subsequent revisions by FERC, and shall use the form of annual report provided by the commission; provided that any class D or class E gas public utility may at its option keep its books and records in compliance with the uniform system of accounts for class D gas utilities, 1958, adopted by NARUC at its annual convention in 1958.
[17.3.610.12 NMAC - Rp, 17 NMAC 3.610.12 NMAC, 12/27/2022]

17.3.610.13 EFFECT OF ADOPTION OF UNIFORM SYSTEMS OF ACCOUNTS: The adoption of the respective uniform systems of accounts by 17.3.610 NMAC shall not be construed as approval or acceptance of any item recorded pursuant to the system of accounts on the books of any utility for the purpose of fixing rates or determining other matters before the commission. The systems of accounts are designed to record the facts of the operations of all gas utilities in a uniform manner. When engaged in fixing rates or passing upon other matters before it the commission will determine what consideration shall be given to various items recorded in the several accounts.
[17.3.610.13 NMAC - Rp, 17 NMAC 3.610.13 NMAC, 12/27/2022]

17.3.610.14 ANNUAL REPORTING:

A. Each utility affected by 17.3.610 NMAC shall report to the commission annually for each calendar year not later than April 30 of the following year upon forms provided by the commission. Attached to this report shall be SEC form 10K, if applicable, and 17.3.610 NMAC form 1 regarding jurisdictional customer numbers. Each utility shall retain one copy of the report in its files.

B. Each utility affected by 17.3.610 NMAC shall provide a detailed report annually for each calendar year not later than April 30 of the following year setting forth and listing its compliance or failure to comply with each part of the commission's final order in each of the cases decided that the utility has a requirement of compliance ordered in the preceding five years or since the utility's last general rate case order, whichever period is longer.

C. The staff of the utility division will review the annual reports for compliance and will, in writing, request additional information from the utility if required. Staff will summarize the annual reports and the division director of the utility division will provide a written report to the commission on or before July 1 of the report year.
[17.3.610.14 NMAC - Rp, 17 NMAC 3.610.14 NMAC, 12/27/2022]

HISTORY OF 17.3.610 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records-State Records Center and Archives.
PSC 68-1, Statutes, General Orders, filed 1/16/1968.
PSC 70-1, Statutes and General Orders, filed 7/9/1970.
NMPSC Rule 610, Uniform Systems Of Accounts And Annual Report Forms, filed 6/30/1988.

History of Repealed Material: 17 NMAC 3. 610**,** Uniform Systems Of Accounts And Annual Report

Forms filed (6/30/1988) effective 12/27/2022.

Other: 17 NMAC 3. 610**,** Uniform Systems Of Accounts And Annual Report Forms filed (6/30/1988) replaced by 17.3.610 NMAC, Uniform Systems Of Accounts And Annual Report Forms effective. (12/27/2022).

PUBLIC REGULATION COMMISSION

TITLE 17 PUBLIC UTILITIES AND UTILITY SERVICES
CHAPTER 5 UTILITY INTERCONNECTIVITY AND COOPERATIVE AGREEMENTS
PART 440 EXTENSIONS, SYSTEM IMPROVEMENTS, REPAIRS OR REPLACEMENTS, ADDITIONS, AND COOPERATIVE AGREEMENTS BETWEEN OR AMONG UTILITIES

17.5.440.1 ISSUING AGENCY: New Mexico public regulation commission.
[17.5.440.1 NMAC - Rp, 17.5.440.1 NMAC, 12/27/2022]

17.5.440.2 SCOPE: This rule applies to investor-owned electric, gas, water, and sewer utilities subject to the jurisdiction of the New Mexico public regulation commission, however, Subparagraph (a) of Paragraph (1) of Subsection A of 17.5.440.8 NMAC and Paragraph (3) of Subsection C of 17.5.440.8 NMAC shall apply to all electric utilities, and Subparagraph (a) of Paragraph (1) of Subsection A of 17.5.440.9 NMAC and Paragraph (2) of Subsection D of 17.5.440.9 NMAC shall apply to all gas, water, and sewer utilities, subject to the jurisdiction of the New Mexico public regulation commission.
[17.5.440.2 NMAC - Rp, 17.5.440.2 NMAC, 12/27/2022]

17.5.440.3 STATUTORY AUTHORITY: Paragraph (10) of Subsection B of Section 8-8-4 NMSA 1978 and Section 8-8-15 NMSA 1978.
[17.5.440.3 NMAC - Rp, 17.5.440.3 NMAC, 12/27/2022]

17.5.440.4 DURATION: Permanent.
[17.5.440.4 NMAC - Rp, 17.5.440.4 NMAC, 12/27/2022]

17.5.440.5 EFFECTIVE DATE: December 27, 2022, unless a later date is cited at the end of a section.
[17.5.440. NMAC - Rp, 17.5.440.5 NMAC, 12/27/2022]

17.5.440.6 OBJECTIVE: This rule is intended to provide reporting and filing requirements and guidance for public utilities and utility division staff.
[17.5.440.6 NMAC - Rp, 17.5.440.6 NMAC, 12/27/2022]

17.5.440.7 DEFINITIONS: As used in this rule:

A. "repairs or replacements" means any public utility activity, that is also a capital expenditure, that repairs, or replaces with the same or substantially similar, equipment or property that has either failed, is in the process of failing, or deteriorated, or that is at the end of its useful life, or that is otherwise necessary to repair or replace; and

B. "undertaking" means the extension, system improvement, repair or replacement, or addition for which the public utility is required to report to the Commission pursuant to 17.5.440.8 NMAC and 17.5.440.9 NMAC.
[17.5.440.7 NMAC - Rp, 17.5.440.7 NMAC, 12/27/2022]

17.5.440.8 ELECTRIC UTILITIES:

A. Report requirements for extensions, system improvements, repairs or replacements, or additions:

(1) A public utility shall, prior to making any of the following described extensions, system improvements, repairs or replacements, or additions as set forth in Subparagraphs (a) through (e) of 17.5.440.8 NMAC below, file a report with the commission setting forth the character of the undertaking, the purpose sought thereby to be accomplished, the means by which that purpose is intended to be realized, the estimated costs involved in the employment of those means, the data upon which the engineering and economic feasibility of the undertaking is based, any reasonable alternatives to the proposed undertaking that have been considered, any system upgrades that may be needed due to the undertaking, and, if Subparagraph (a) of 17.5.440.8 NMAC below is applicable, the name or names of the utility or utilities toward which the proposed extension is to be made.

(a) Any extension, of any electric facility outside the limits of a municipality to a point within one-half mile of the facilities of any other utility or utilities rendering electric service.

(b) Any extension, system improvement, repairs or replacements, or addition to any transmission or distribution line, plant, facility, or system, exclusive of generating facilities, which will have an estimated cost to the utility under the uniform system of accounts of $1,000,000 or more on a total company basis and for which the utility intends to seek rate recovery from its New Mexico customers, regardless of the location of the line, plant, facility, or system.

(i) In calculating the estimated cost, the utility shall include the cost of any system upgrades that are directly related to, or required as a result of, such addition, repair or replacement, or system improvement.

(ii) The estimated cost shall be reasonable and proposed in good faith.

(c) Any addition to, or repair or replacement of, or improvement of, any electric generating facility which will have an estimated cost to the utility under the uniform system of accounts of $2,000,000 or more on a total company basis and for which the

utility intends to seek rate recovery from its New Mexico customers, regardless of the location of the electric generating facility.

(i) In calculating the estimated cost, the utility shall include the cost of any system upgrades that are directly related to, or required as a result of, such addition, repair or replacement, or system improvement.

(ii) The estimated cost shall be reasonable and proposed in good faith.

(d) Substantial system characteristic improvements involving a change in operating voltage of electric lines. Substantial system characteristic improvements involving reconductoring, rephasing (addition or deletion of phases) of electric lines resulting in a length of two miles or more. System improvements of an overall or system wide nature shall be submitted to the commission as an overall plan.

(e) Any extensions, system improvements, repairs or replacements, or additions for which the public utility claims or intends to claim safe harbor under 17.9.592.15 NMAC that have an estimated cost to the utility under the uniform system of accounts of $1,000,000 or more on a total company basis and for which the utility intends to seek rate recovery from its New Mexico customers, regardless of the location of the undertaking.

(i) In calculating the estimated cost, the utility shall include the cost of any system upgrades that are directly related to, or required as a result of, such extension, system improvement, repair or replacement, or addition.

(ii) The estimated cost shall be reasonable and proposed in good faith.

(2) The report is for informational purposes and shall not constitute nor be deemed to constitute an application by the utility for authority to engage in the reported undertaking.

(3) Reports shall include sufficient information to enable the commission to appropriately relate the proposed extension, system improvement, repair or replacement, or addition to maps of existing facilities.

(4) The utility shall file reports on forms to be furnished by the commission and shall be numbered serially.

B. The commission shall not be precluded from requiring the filing of further information by the reporting utility with respect to its proposed undertaking.

C. Filing and service procedures:

(1) The utility shall file a report at least 30 days prior to the commencement of construction of the extension, system improvement, repair or replacement, or addition, except in the event of unplanned emergency undertakings, in which case the report shall be filed not more than 30 days after the onset of the emergency.

(2) Upon the utility's filing of a report, commission utility division staff shall review the report and notify by email the utility, office of general counsel, and the individual commissioners of statutory, regulatory, or feasibility issues, if any, within a reasonable time prior to the commencement of construction, or within a reasonable time following the filing of a report on an unplanned emergency undertaking.

(3) Where a utility is required to file a report with the commission pursuant to Subparagraph (a) of Paragraph (1) of Subsection A of 17.5.440.8 NMAC, the utility shall, at the time of filing its report with the commission, serve a copy of the filed report on the utility or utilities toward whose facilities the extension is proposed to be made.

(a) Proof of service of such copy shall be made and filed with the commission under the certificate of the person making the service.

(b) If the service is made by mail, it shall be made by certified mail with return receipt requested, it shall include the corresponding 440 filing number, and the return receipt shall be filed with the commission with the proof of service.

(c) Thereafter, no complaint by a utility in opposition to the proposed extension will be entertained by the commission unless filed with the commission by the opposing utility within 20 days of its receipt of the served copy of the report.

(d) The provisions of this section will be waived whenever the commission is furnished proof in writing that the utility toward whose facilities the extension is proposed to be made has no complaints.

(4) A public utility shall notify each individual commissioner by email when it files a report or amended report with estimated or actual costs of $8,000,000 or more on a total company basis.

D. Duty to amend report:

(1) Prior to any request for rate recovery for the undertaking, the utility shall amend a report to update the undertaking's estimated costs, if the estimates increased or decreased by greater than twenty percent, and to reflect the utility's actual costs incurred for that undertaking.

(a) In its amended report, the utility shall provide explanations for why its initial estimated costs were inaccurate and why its actual costs fell below or exceeded its estimated costs.

(b) The amended report shall be included with the utility's request for rate recovery.

(2) The utility shall amend a report to accurately reflect the undertaking's materially altered character or purpose, or if the utility pursues a reported alternative, pursuant to Paragraph (1) of Subsection A of 17.5.440.8 NMAC, at least 30 days prior to the commencement of construction of the extension, system improvement,

repair or replacement, or addition. If a utility files an amended report pursuant to this Paragraph, commission utility division staff shall follow the procedures of Paragraph (2) of Subsection C of 17.5.440.8 NMAC above.
[17.5.440.8 NMAC -Rp, 17.5.440.9 NMAC, 12/27/2022]

17.5.440.9 GAS, WATER, AND SEWER UTILITIES:

A. Report requirements for extensions, system improvements, and additions:

(1) Each public utility shall, prior to making any of the following described extensions, system improvements, or additions as set forth in Subparagraphs (a) through (d) of 17.5.440.9 NMAC below, file a report with the commission setting forth the character of the undertaking, the purpose sought thereby to be accomplished, the means by which that purpose is intended to be realized, the estimated costs involved in the employment of those means, the data upon which the engineering and economic feasibility of the undertaking is based, any reasonable alternatives to the proposed undertaking, and, if Subparagraph (a) of 17.5.440.9 NMAC below is applicable, the name or names of the utility or utilities toward which the proposed extension is to be made.

(a) Any extension of or any change in the routing of any distribution or transmission line which will extend to within one-half mile of the facilities of any other utility or utilities rendering the same kind of service.

(b) Any extension, system improvement, or addition to any transmission or distribution line, plant, facility, or system which will have an estimated cost under the uniform system of accounts of $200,000 or more on a total company basis and for which the utility intends to seek rate recovery from its New Mexico customers, regardless of the location of the line, plant, facility, or system.

(c) Any extension or system improvement one-half mile or more in length of any transmission or distribution line outside of any municipality which involves any changes in routing, pipe size, pipe material, or design pressure for gas or water lines.

(d) Any extension of one-half mile or more in length within the limits of a municipality where the pressure is in excess of 400 p.s.i.

(2) The report is for informational purposes and shall not constitute an application by the utility for authority to engage in the reported undertaking.

(3) Reports shall include sufficient information to enable the commission to appropriately relate the proposed extension, system improvement, or addition to maps of existing facilities.

(4) The utility shall file reports on forms to be furnished by the commission and shall be numbered serially.

B. The commission shall not be precluded from taking any action which it deems appropriate with respect to reports filed pursuant to this rule and the undertaking.

C. The commission shall not be precluded from requiring the filing of further information by the reporting utility with respect to its proposed undertaking.

D. Service procedure and policy:

(1) Upon the utility's filing of a report, commission utility division staff shall review the report and notify the Commission of statutory, regulatory, or feasibility issues, if any, and shall recommend appropriate actions to be taken, if any, pursuant to Subsections B and C of 17.5.440.9 NMAC above, as determined by staff.

(2) Where a utility is required to file a report with the commission pursuant to Subparagraph (a) of Paragraph (1) of Subsection A of 17.5.440.9 NMAC, the utility shall at the time of filing its report with the commission serve a copy of the filed report on the utility or utilities toward whose facilities the extension is proposed to be made.

(a) Proof of service of such copy shall be made and filed with the commission under the certificate of the person making the service.

(b) If the service in made by mail, it shall be made by certified mail with return receipt requested, it shall include the corresponding 440 filing number, and the return receipt shall be filed with the commission with the proof of service.

(c) Thereafter, no complaint by a utility in opposition to the proposed extension will be entertained by the commission unless filed with the commission by the opposing utility within 20 days of its receipt of the served copy of the report.

(d) The provisions of this section will be waived whenever the commission is furnished proof in writing that the utility toward whose facilities the extension is proposed to be made has no complaints.
[17.5.440.9 NMAC - Rp, 17.5.440.10 NMAC, 12/27/2022]

17.5.440.10 ANNUAL REPORT:

A. Each public utility shall, by March 31 of each calendar year, file a report with the commission summarizing:

(1) each of the utility's filings pursuant to 17.5.440.8 NMAC or 17.5.440.9 NMAC for the prior calendar year, as described in Subsection B of 17.5.440.10 NMAC below;

(2) each of the utility's planned filings pursuant to 17.5.440.8 NMAC or 17.5.440.9 NMAC for the following 365-day period, as described in Subsection C of 17.5.440.10 NMAC below; and

(3) the utility's projects from the prior calendar year that were not deemed undertakings pursuant to Subparagraphs (b) and (c) of Paragraph (1) of Subsection A of 17.5.440.8 NMAC, and Subparagraph

(b) of Paragraph (1) of Subsection A of 17.5.440.9 NMAC, as described in Subsection D of 17.5.440.10 NMAC below.

B. Annual reports shall contain the following information for each filing pursuant to 17.5.440.8 NMAC or 17.5.440.9 NMAC of the prior calendar year:

(1) filing and construction commencement dates;

(2) category of report pursuant to Paragraph (1) of Subsection A of 17.5.440.8 NMAC or Paragraph (1) of Subsection A of 17.5.440.9 NMAC;

(3) estimated and actual costs, as may be amended, associated with each of the reported extensions, system improvements, repairs or replacements, or additions;

(4) general locations of the extensions, system improvements, repairs or replacements, or additions; and

(5) a short description, including a project status update, of the reported extensions, system improvements, repairs or replacements, or additions.

C. Annual reports shall contain the following information for every planned filing pursuant to 17.5.440.8 NMAC or 17.5.440.9 NMAC to be made during the following 365-day period:

(1) planned filing and construction commencement dates or timeframe;

(2) category of report pursuant to Paragraph (1) of Subsection A of 17.5.440.8 NMAC or Paragraph (1) of Subsection A of 17.5.440.9 NMAC;

(3) estimated costs associated with each of the extensions, system improvements, repairs or replacements, or additions;

(4) planned location of the extensions, system improvements, repairs or replacements, or additions;

(5) a short description of the extensions, system improvements, repairs or replacements, or additions, including the adjacent infrastructure to which the extensions, system improvements, repairs or replacements, or additions are expected to interconnect, and the third parties with whom the utility expects to engage with contractually; and

(6) any reasonable alternatives to the planned extensions, system improvements, repairs or replacements, or additions.

D. Annual reports shall include, for the prior calendar year, the aggregated total actual costs (not individual project costs) of all extensions, system improvements, repairs or replacements, and additions that are not required to be reported pursuant to Subparagraphs (b) and (c) of Paragraph (1) of Subsection A of 17.5.440.8 NMAC due to falling below the cost thresholds. Annual reports shall include the same information as estimated for the following 365-day period.

E. Annual reports shall include the aggregated total estimated and actual costs for all reports, and for each individual category of report pursuant to Paragraph (1) of Subsection A of 17.5.440.8 NMAC or Paragraph (1) of Subsection A of 17.5.440.9 NMAC, for extensions, system improvements, repairs or replacements, or additions made during the prior calendar year.

F. Annual reports shall include the aggregated total estimated costs for all of the utility's planned filings pursuant to 17.5.440.8 NMAC or 17.5.440.9 NMAC for the following 365-day period. The estimated total cost shall be reasonable and proposed in good faith.

G. Commission staff shall notify the commission of a public utility's noncompliance with 17.5.440.10 NMAC within 60 days of the filing of the annual report.

[17.5.440.10 NMAC - N, 12/27/2022]

HISTORY: Codified by NMPSC Case No. 2086, order dated June 30, 1988; Amended by NMPSC Case No. 2232, order dated December 19, 1988; Amended by NMPSC Case No. 2277, order dated December 29, 1989. Formerly NMPSC Second Revised General Order No. 10, superseded for purposes of rule reorganization and codification.

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives.
PSC 68-1, Statutes, General Orders, filed 1/16/1968.
PSC 70-1, Statutes and General Orders, filed 7/9/1970.
NMPSC Rule 440, Extensions, Improvements, Additions, and Cooperative Agreements Between or Among Utilities, filed 6/30/1988.

History of Repealed Material:
NMPSC Rule 440, Extensions, Improvements, Additions, and Cooperative Agreements Between or Among Utilities, filed 6/30/88 - Repealed effective 5/15/2013.
17.5.440 NMAC, Extensions, Improvements, Additions, and Cooperative Agreements Between or Among Utilities filed 5/1/2013, Repealed effective 12/27/2022.

Other: 17.5.440 NMAC, Extensions, Improvements, Additions, and Cooperative Agreements Between or Among Utilities filed 5/1/2013, Replaced by Extensions, System Improvements, Repairs or Replacements, Additions, And Cooperative Agreements Between or Among Utilities effective 12/27/2022.

PUBLIC REGULATION COMMISSION

This is an amendment to 17.1.2 NMAC, Sections 3 and 10, effective 12/27/2022.

17.1.2.3 STATUTORY AUTHORITY: [~~Paragraph (1) of Subsection B of 8-8-4 NMSA 1978, and 62-8-3 NMSA 1978.~~] Section 8-8-4 NMSA 1978 and Section 62-8-3 NMSA 1978.

[17.1.2.3 NMAC - Rp, 17 NMAC 1.2.3, 9/1/2008; A, 12/27/2022]

17.1.2.10 APPLICATIONS FOR NEW RATES:

A. General: This

section applies to all filings seeking new rates, except as otherwise provided by statute or by commission rule or order.

B. Filings seeking new rates:

(1) Proceedings involving new rates shall be initiated by advice notice notifying the commission of the utility's intent to implement new rates by a certain date which may not be less than 30 days after the filing of such notice.

(a) The utility shall file with the advice notice direct testimony and supporting exhibits in written form, including any rate filing package required by commission rule or order.

(b) In a general rate case the utility shall also file a petition setting forth the concise statement, supported by direct testimony and exhibits, required by Subparagraph (c) of Paragraph (2) of Subsection B of 17.1.2.10 NMAC.

(c) All advice notices shall conform to the requirements of Schedule of Rates, Rules, and Forms, 17.1.210 NMAC.

(d) The utility shall serve a copy of the advice notice on the attorney general and all counsel of record and pro se parties in the utility's last rate case at the time it files the advice notice with the commission but need not accompany the copy with testimony and exhibits.

(2) The utility shall submit the following with its filing.

(a) A copy of the notice to be sent to ratepayers and published pursuant to Subsection C of 17.1.2.10 NMAC. At the time of submission the notice shall be complete except as to the date, time, and place of the hearing and the deadline for intervention, which information will be provided to the utility before it sends the notice to newspapers and ratepayers. The notice shall be in the form prescribed by the commission and shall be subject to approval by the commission or presiding officer as to form. The commission or presiding officer shall provide the date, time, and place of the hearing and the deadline for intervention and issue its approval of or corrections to the form of notice within 20 days after the commission issues its order suspending the proposed rates and assigning the matter to a hearing examiner, if such assignment is made.

(b) A statement comparing the new rate or rates with the present rate or rates, which statement shall contain the information required in Subparagraphs (a) through (e) of Paragraph (2) of Subsection C of 17.1.2.10 NMAC.

(c) In general rate cases, a concise statement supported by the direct testimony and exhibits identifying:

(i) whenever the utility proposes to change the ratemaking treatment upon which the present rates are based, each proposed change, the reasons for the proposed change, and the impact in dollars of the proposed change on the rates being requested; and

(ii) any extraordinary event or circumstance, known or projected, which materially alters the utility's operating or financial condition from the condition existing during the utility's test period in its last rate case.

[~~(d)~~ ~~A concise statement setting forth its compliance or failure to comply with each part of the commission's final order in each of the utility's cases decided during the preceding five (5) years. Combination utilities shall provide this statement with respect to the utility operation for which the rate change is being sought. This requirement shall not apply in the event the utility elects to make an annual informational financing filing on a date certain each year setting forth the requested information.~~]

(3) Failure to abide by the requirements set forth in this subsection may be deemed grounds for rejection of the filing.

C. Notice of hearing:

(1) Notice to general public: A utility filing for new rates shall cause notice of the hearing on the proposed rates to be published in a newspaper of general circulation available in every county where the utility provides service and in such other counties as the commission or presiding officer by order may determine.

(a) Such notice shall be published within 40 days of the date of the order of the commission or presiding officer setting the date, time, and place of the hearing and approving the form of notice.

(b) The notice shall appear at least once and shall contain the information set forth in Paragraph (2) of Subsection C of 17.1.2.10 NMAC.

(c) The utility making the application for new rates shall bear the cost of publication.

(d) The utility shall ensure that an affidavit of publication is filed promptly upon publication of the notice.

(2) Notice to ratepayers: Every utility seeking a change in rates shall notify affected customers of the pendency of the application for new rates. Such notice shall be given no later than 40 days after the date of the order of the commission or presiding officer setting the date, time, and place of the hearing and approving the form of notice and shall include the following information:

(a) the amount of the change requested, in both dollar amounts and percentage change;

(b) the customer classifications to which the rate change will apply;

(c) the present rates and the proposed rates for each customer class to which the proposed rates would apply;

(d) for residential customers without demand meters, the present bill and the anticipated bill for each of the following levels of consumption or closest reasonable equivalent units:

(i) for electric service: 0 kwh, 250 kwh, 500 kwh, 750 kwh, 1,000 kwh, and 2,000 kwh;

(ii) for gas service: 0 therms, 50 therms, 100 therms, 200 therms, and 300 therms;

(iii) for water service: 0 gallons, 5,000 gallons, 10,000 gallons, 15,000 gallons, and 25,000 gallons; and

(iv) for sewer service: 0 gallons, 5,000 gallons, 10,000 gallons, 15,000 gallons, and 25,000 gallons, or fixed charge if applicable;

(e) a statement that the rate changes stated by class and, for residential customers, by consumption levels are for informational purposes only and that the final rate design may vary the rates ultimately charged to each class and for each consumption level;

(f) the commission case number assigned to the proceeding and the schedule ordered by the commission or presiding officer for the proceeding including the date, time, and place of hearing as well as other procedural dates established by the commission or presiding officer together with the further statement that interested persons should contact the commission for confirmation of the hearing date, time, and place since hearings are on occasion rescheduled;

(g) the statement that any interested person may examine the rate filings together with any exhibits and related papers that may be filed at the main office of the utility or at the offices of the commission in Santa Fe, and indicating the addresses and telephone numbers of both the utility and the commission;

(h) a statement that a person may intervene by filing a motion for leave to intervene pursuant to this rule on or before a date to be stated in the notice, such date to correspond to the deadline established by this rule or ordered by the commission or presiding officer pursuant to this rule;

(i) a statement that any interested person may appear at the time and place of hearing and make a written or oral comment at the hearing pursuant to this rule without becoming an intervenor, but that the comment will not be considered as evidence in the proceeding;

(j) a statement that this rule will apply to the proceeding except as modified by order of the commission or presiding officer in the proceeding; and

(k) a statement that further information may be obtained by contacting either the utility or the commission.

(3) The commission or presiding officer may by order require such other notice of the proceeding as is deemed proper under the circumstances.

(4) Failure to comply with this section may result in a dismissal of the application.

[17.1.2.10 NMAC - Rp, 17 NMAC 1.2.53, 9/1/2008; A, 12/27/2022]

PUBLIC REGULATION COMMISSION

This is an amendment to 17.9.592 NMAC, Sections 2, 3, 6, 7, 9, 10, 11, 12, 14, 15, effective 12/27/2022.

17.9.592.2 SCOPE: This rule applies to all persons seeking to construct a large capacity plant, whether or not owned or operated by a person that is a public utility subject to regulation by the commission, or [~~a~~] transmission lines in connection with such a plant, on a location within New Mexico.

[17.9.592.2 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.3 STATUTORY AUTHORITY: [~~NMSA 1978 Sections 8-8-4 and 62-9-3~~] Section 8-8-4 NMSA 1978 and Section 62-9-3 NMSA 1978.

[17.9.592.3 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.6 OBJECTIVE: The purpose of this rule is to specify the contents of an application for approval of the location of a large capacity plant or transmission line pursuant to [~~NMSA 1978~~] Section 62-9-3 NMSA 1978.

[17.9.592.6 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.7 DEFINITIONS: In addition to the definitions in [~~NMSA 1978~~] Section 62-3-3 NMSA 1978, as used in this rule:

A. "large capacity plant" means an electric generating plant in a location within New Mexico designed for, or capable of, operation at a capacity of [~~three hundred thousand (300) kilowatts~~] 300 megawatts or more, for the generation of electricity for sale to the public within or without New Mexico;

B. "NEPA" means the National Environmental Policy Act, 42 U.S.C. Section 4321 et seq.; and

C. "transmission line" means any electric transmission line, including its interconnection facilities and associated facilities, designed for, or capable of, operations at a nominal voltage of 230 kilovolts or more, to be constructed in connection with, and to transmit electricity from, a large capacity plant constructed after June 18, 1971.

[17.9.592.7 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.9 CONTENTS OF APPLICATION FOR LOCATION APPROVAL OF LARGE CAPACITY PLANT: A person seeking to construct a large capacity plant [~~must~~] shall file with the commission an application for approval of location, supported by written direct testimony and supporting exhibits, which shall contain:

A. a description of the large capacity plant, including, but not limited to:

(1) a legal description of the property upon which the large capacity plant will be located;

(2) the size of the large capacity plant;

(3) fuel specifications including, but not limited to, the type of fuel to be used, if applicable, and any secondary fuel capability, if applicable; and

(4) a map showing the location of the large capacity plant;

B. identification of all applicable land use statutes and administrative regulations, and proof of compliance or a statement of noncompliance with each;

C. identification of all applicable air and water pollution control standards and regulations, and proof of compliance or a statement of noncompliance with each;

[~~**D.** all written air and water quality authorizations necessary to begin constructions of the large capacity plant;~~]

[~~**E.**~~] **D.** all written air and water quality authorizations necessary to begin construction, and necessary to begin operation, of the large capacity plant; if any such authorization cannot be obtained until after construction of the large capacity plant, proof of application for such authorization;

[~~**F.**~~] **E.** the expected date that the large capacity plant will be online;

[~~**G.**~~] **F.** proof that the application has been served on all local authorities in each county and township where the large capacity plant will be located, the New Mexico attorney general, the New Mexico environment department, and the New Mexico state engineer; and

[~~**H.**~~] **G.** any other information, including photographs, which the applicant wishes to submit in support of the application.

[17.9.592.9 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.10 CONTENTS OF APPLICATION FOR LOCATION APPROVAL OF TRANSMISSION LINE: A person seeking to construct a transmission line [~~must~~] shall file with the commission an application for approval of location, supported by written direct testimony and supporting exhibits, which shall contain:

A. a description of the transmission line including, but not limited to:

(1) the location of the transmission line and a map depicting the location in electronic format and physical format with a scale not to exceed one inch equals five miles;

(2) identification of the ownership of the land (such as private, bureau of land management, U.S. forest service, state trust, etc.) the transmission line will cross, and the number of feet the transmission line will cross over each owner's land;

(3) the total length of each transmission line in feet;

(4) a description of interconnection facilities; and

(5) a schematic diagram showing the transmission line and the interconnection of the transmission line to the transmission grid;

B. identification of all applicable land use statutes and administrative regulations, and proof of compliance or statement of noncompliance with each;

C. if required under NEPA, an environmental assessment prepared in connection with the transmission line;

D. if required under NEPA, an environmental impact statement and record of decision, or a finding of no significant impact, prepared in connection with the transmission line;

E. if preparation of a federal environmental assessment or environmental impact statement is not required under NEPA in connection with the transmission line, then a report, comparable to an environmental impact statement, in the format prescribed in 40 C.F.R. Section 1502.10;

F. [~~all written federal, state, and local environmental authorizations necessary to begin construction of the transmission line;~~

~~**G.**~~] all written federal, state, and local environmental authorizations necessary to begin construction, and necessary to begin operation, of the transmission line; if any such authorization cannot be obtained until after construction of the transmission line, proof of application for such authorization;

[~~**H.**~~] **G.** testimony demonstrating that the transmission line will not unduly impair important environmental values; important environmental values include, but are not limited to: [~~preservation of air and water quality, land uses, soils, flora and fauna, and water, mineral, socioeconomic, cultural, historic, religious, visual, geologic and geographic resources;~~]

(1) preservation of air quality and water quality;

(2) preservation of land uses, soils, flora, and fauna; and

(3) preservation of water resources, mineral resources, socioeconomic resources, cultural resources, historic resources, religious resources, visual resources, geologic resources, and geographic resources.

[~~**I.**~~] **H.** the expected date that the transmission line will be online;

[~~**J.**~~] **I.** proof that the application has been served on all local authorities in each county and township where the transmission line will be located, the New Mexico attorney general, the New Mexico environment department, and the New Mexico state engineer; and

[~~**K.**~~] **J.** any other information, including photographs, which the applicant wishes to submit in support of the application.

[17.9.592.10 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.11 ADDITIONAL INFORMATION: Upon request from the commission or commission staff, a person seeking approval from the commission of the location of a large capacity plant or transmission

line shall, within [~~thirteen (13)~~] 13 days of the date that the request is mailed, submit any additional information the commission or commission staff believes is required to approve or deny the application. The commission and commission staff's authority to request additional information does not preclude or restrict interveners from exercising their discovery rights.
[17.9.592.11 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.12 INCOMPLETE FILINGS: To be complete, an application [~~must~~] shall meet all applicable requirements of this rule. If the commission determines that an application is incomplete, the commission shall advise the applicant of the deficiency in the application within [~~thirty (30)~~] 30 days of its receipt. The commission [~~will~~] shall commence its review of an application, and the statutory deadline in [~~NMSA 1978~~] Section 62-9-3 NMSA 1978 shall [~~begin to be computed,~~] commence once the commission receives all the information and supporting documentation required by this rule.
[17.9.592.12 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.14 VARIANCE:

A. An applicant may request a variance from any of the requirements of this rule.

B. A petition for variance [~~must~~] shall be supported by an affidavit signed by an officer of the applicant or someone with authority to sign for the applicant.

C. The commission may, at its discretion, require an informal conference or formal evidentiary hearing prior to making its determination.

D. A petition for variance shall:

(1) identify the section of this rule for which the variance is requested;

(2) describe the situation that necessitates the variance;

(3) describe the effect of complying with this rule on the applicant if the variance is not granted; and

(4) describe the result the variance will have if granted.

E. The six-month review period under [~~NMSA 1978~~] Section 62-9-3 NMSA 1978 shall be stayed, beginning the date that a request for variance is filed, and ending the date that a variance petition is granted, or, if the variance petition is denied, the date that the applicant submits the information for which the applicant sought a variance.
[17.9.592.14 NMAC - N, 5/1/2004; A, 12/27/2022]

17.9.592.15 SAFE HARBOR:

A. The following shall be considered additions to, or modifications of, an existing plant or transmission line for which, under [~~Section 62-9-3(D) NMSA 1978,~~] Subsection D of Section 62-9-3 NMSA 1978, no location approval is required. The "existing right-of-way" shall relate to the existing plant's or existing transmission line's existing right-of-way and shall be in place at the time that the safe harbor claim is made.

(1) [~~maintenance~~] Maintenance, repairs, and rebuilding, such as phase raising, installation of clearance improvements, replacement or reframing of structures, or line reconductoring entirely within the existing right-of-way.

(2) [~~addition~~] Addition of circuits or placement of additional structures; for transmission lines these shall be entirely within the existing right-of-way or entirely within [~~twelve hundred (1200)~~] 1,200 feet of the existing right-of-way not adjacent to a developed residential, commercial, or industrial area.

(3) [~~voltage~~] Voltage upgrades to a transmission line for which location approval at the upgraded voltage level has already been granted, or voltage upgrades to a transmission line for which the commission by written order has determined that location approval is not required.

(4) [~~emergency~~] Emergency construction due to facilities being out of service or where a failure of a facility is imminent, so long as construction remains entirely within the existing right-of-way or entirely within [~~twelve hundred feet (1200)~~] 1,200 feet of the existing right-of-way not adjacent to a developed residential, commercial, or industrial area.

(5) [~~construction~~] Construction of a tap line to a new terminus, both of which are entirely within the existing right-of-way or entirely within [~~twelve hundred feet (1200)~~] 1,200 feet of the existing right-of-way not adjacent to a developed residential, commercial, or industrial area.

(6) [~~replacements~~] Replacements to transmission-related electrical stations located entirely within the existing right-of-way or entirely within [~~twelve hundred feet (1200)~~] 1,200 feet of such electrical stations not adjacent to a developed residential, commercial, or industrial area.

(7) [~~erection~~] Erection of temporary facilities for [~~twelve (12)~~] 12 months or less entirely within the existing right-of-way or entirely within [~~twelve hundred feet (1200)~~] 1,200 feet of the existing right-of-way not adjacent to a developed residential, commercial, or industrial area.

B. Notwithstanding the foregoing provisions, if new or replacement conductors, or new or replacement structures will extend for a distance of over one [~~(1)~~] mile in length for a transmission line, [~~with a voltage of two hundred-thirty (230) kilovolts or greater~~] the following requirements shall apply so long as they can be accomplished at reasonable additional cost:

(1) to the extent commercially available, non-specular conductors shall be used in any developed or trafficked areas, unless they pose a significant threat to avian populations; and

(2) structures shall be consistent with, and minimize visual impacts to, the landscape of the area in which the structure is constructed: rural, urban, or industrial.

C. Prior to any person constructing, modifying, or adding to plants, facilities, or transmission lines that require location control under Section 62-9-3 NMSA 1978 on land owned or controlled by a federally recognized American Indian tribe, or on land contiguous to such [~~Indian~~] tribal land, that person shall consult with the tribe that owns or controls that land regarding the location of the construction. This required consultation is in addition to meeting the requirements of both Section 62-9-3 NMSA 1978 and this rule.

D. At least [~~one hundred-twenty (120)~~] 120 days before a person commences any activity or installation not listed in Paragraphs (1) to (7) of Subsection A of Section 15 of 17.9.592 NMAC above, that person (the petitioner) shall file with the commission a petition requesting that the commission determine whether location approval is required. The petitioner shall serve a copy of the petition on:

(1) all landowners whose land is adjacent to, or encompassed by, the location of the proposed activity or installation; and

(2) all parties in the public utility's last rate case, if the petitioner is a public utility.

E. Public utilities that claim safe harbor for any extensions, system improvements, repairs or replacements, or additions, pursuant to Paragraphs (1) to (7) of Subsection A of Section 15 of 17.9.592 NMAC above, that has an estimated cost to the utility under the uniform system of accounts of $1,000,000 or more on a total company basis and for which the utility intends to seek rate recovery from its New Mexico customers, regardless of the location, shall file a "440 report" with the commission pursuant to Subparagraph (e) of Paragraph (1) of Subsection A of 17.5.440.8 NMAC.

[~~**E.**~~] **F.** Commission staff shall, and any interested party who files a motion to intervene may, file a response to the petition within [~~forty-five (45)~~] 45 days of its filing with the commission. If the commission does not act on the petition within [~~one hundred (100)~~] 100 days from the date the petition was filed with the commission, the facilities that are the subject of the petition shall be deemed to be additions to, or modifications of, an existing plant or transmission line for the purposes of Subsection D of Section 62-9-3 NMSA 1978, [~~Section 62-9-3(D) NMSA 1978,~~] for which location approval shall not be required [~~under Section 62-9-3 NMSA 1978~~]. The commission's lack of action on a petition within the [~~one hundred (100)~~] 100 day period shall not affect any requirement to obtain a certificate of public convenience and necessity pursuant to Section 62-9-1 NMSA 1978.

[17.9.592.15 NMAC - N, 8/31/2011; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
ACUPUNCTURE AND ORIENTAL MEDICINE, BOARD OF

The New Mexico Board Acupuncture and Oriental Medicine reviewed at its 11/30/2022 hearing, to repeal its rule 16.2.6 NMAC, Acupuncture and Oriental Medicine Practitioners - Reciprocal Licensing filed 11/1/2001 and replace it with 16.2.6 NMAC Acupuncture and Oriental Medicine Practitioners - Expedited Licensing, adopted 12/12/2022 and effective 12/27/2022.

The New Mexico Board Acupuncture and Oriental Medicine reviewed at its 11/30/2022 hearing, repealed its rule 16.2.21 NMAC - Licensure for Military Service Members, Spouses and Veterans (filed 1/12/2022). The rule repeal adopted 11/12/2022 and is effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
ACUPUNCTURE AND ORIENTAL MEDICINE, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 2 ACUPUNCTURE AND ORIENTAL MEDICINE PRACTITIONERS
PART 6 EXPEDITED LICENSING

16.2.6.1 ISSUING AGENCY: New Mexico Board of Acupuncture and Oriental Medicine.
[16.2.6.1 NMAC - Rp, 16.2.6.1 NMAC 12/27/2022]

16.2.6.2 SCOPE: All licensees and applicants.
[16.2.6.2 NMAC - Rp, 16.2.6.2 NMAC 12/27/2022]

16.2.6.3 STATUTORY AUTHORITY: This part is promulgated pursuant to the Acupuncture and Oriental Medicine Practice Act, Sections 61-14A-8; 61-14A-9; and 61-14A-13 NMSA 1978.
[16.2.6.3 NMAC - Rp, 16.2.6.3 NMAC 12/27/2022]

16.2.6.4 DURATION: Permanent.
[16.2.6.4 NMAC - Rp, 16.2.6.4 NMAC 12/27/2022]

16.2.6.5 EFFECTIVE DATE: December 27, 2022, unless a later date is cited at the end of a section.
[16.2.6.5 NMAC - Rp, 16.2.6.5 NMAC 12/27/2022]

16.2.6.6 OBJECTIVE: The purpose of this part is to provide for the issuance of expedited licenses pursuant to Section 61-1-31.1 NMSA 1978 and Section 61-1-34 NMSA 1978.
[16.2.6.6 NMAC - Rp, 16.2.6.6 NMAC 12/27/2022]

16.2.6.7 DEFINITIONS:

A. "Eligible jurisdiction" means:

(1) any state or territory of the United States except those included in the list of disapproved licensing jurisdictions under 16.2.6.8 NMAC; and

(2) any foreign country included under 16.2.6.8 NMAC.

B. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

C. "Good standing" means a license or registration is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

D. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-2 NMSA 1978.

E. "Licensing fee" has the same meaning as defined in Paragraph (1) of Subsection E of Section 61-1-34 NMSA 1978.

F. "Qualified applicant" means an applicant who:

(1) holds a current license in good standing in an eligible jurisdiction, as defined by Subsection A of this rule;

(2) does not have a disqualifying criminal conviction, as defined in Paragraph (10) of 16.2.3 NMAC of the board's rules; and

(3) is not subject to pending disciplinary action in New Mexico.

G. "Veteran" has the same meaning as defined in Paragraph (3) of Subsection E of Section 61-1-34 NMSA 1978.

[16.2.6.7 NMAC - Rp, 16.2.6.7 NMAC 12/27/2022]

16.2.6.8 LIST OF DISAPPROVED LICENSING JURISDICTIONS; REASONS:

A. Applicants for expedited licensure as doctors of oriental medicine licensed in the following states and territories of the United States shall not be eligible or expedited licensure under Section 61-14A-13 NMSA 1978 of the Acupuncture and Oriental Medicine Practice Act (pursuant to the list of disapproved jurisdiction list, below, only four states are unequivocally approved for purposes of expedited licensure, which include Arkansas, Florida, Nevada, and Texas):

(1) California, on the grounds that it does not recognize the national certification commission for acupuncture and oriental medicine (NCCAOM) examinations or certifications, as it utilizes its own examination, the California acupuncture licensing exam;

(2) Michigan, on the grounds that licensure was not required until 2019 and there were no education or examination requirements for then registered acupuncturists to become licensed through 2024;

(3) Ohio, on the grounds that Ohio no longer licenses oriental medicine professionals and does not allow the use of Chinese herbal medicine by licensed acupuncturists;

(4) Wyoming, on the grounds that licensure was not required prior to 2018, and there were no education or examination requirements consistent with New Mexico's examination requirements, for then registered acupuncturists to become licensed. Further, education requirements cannot be determined to be consistent with New Mexico;

(5) Guam, on the grounds that licensure of acupuncturists is determined based on the licensure an applicant holds in the U.S., and there is no way to determine whether such licensure is consistent with New Mexico other than on a case-by-case basis; and

(6) American Samoa, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Minnesota, Montana, Nebraska, New Hampshire, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin, on the grounds that education and licensure examination requirements in these jurisdictions cannot be determined to be consistent with those requirements in New Mexico;

(7) Northern Mariana Islands, on the grounds that education and licensure examination requirements in this jurisdiction cannot be determined to be consistent with those requirements in New Mexico. Further, licensure as an acupuncturist is allowed if an applicant is licensed in one of the U.S. states or territories, and there is no way to determine whether such licensure is consistent with New Mexico other than on a case-by-case basis; and

(8) Unless the applicant holds a current or active oriental medicine certification from the NCCAOM, Alaska, Arizona, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Kansas, Massachusetts, Mississippi, Missouri, New Jersey, and North Dakota, on the grounds that New Mexico required the rigorous NCCAOM oriental medicine certification.

B. An applicant may not apply for expedited licensure on the basis of practice in any jurisdiction that does not license, register, certify, or regulate the practice of acupuncture or oriental medicine, including each of the following:

(1) Alabama;

(2) Oklahoma;

(3) South Dakota;

(4) Puerto Rico; and

(5) U.S. Virgin Islands.

[16.2.6.8 NMAC - Rp, 16.2.6.8 NMAC 12/27/2022]

16.2.6.9 EXPEDITED LICENSURE APPLICATION:

A. A candidate for expedited licensure under Section

61-1-31.1 NMSA 1978 must submit to the board a complete application containing all the following:

(1) a completed and signed application form;

(2) proof of a current license in good standing from an eligible jurisdiction as defined in these rules;

(3) pass a written jurisprudence examination on the state laws and rules as required by Paragraph (4) of Subsection A of Section 61-14A-13 NMSA 1978;

(4) payment of the required application fee.

B. An expedited license application shall not be deemed complete until the applicant has submitted and the board's staff is in receipt of all the materials required by Subsection A of 16.2.6.11 NMAC, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-14A-17 NMSA 1978:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

[16.2.6.9 NMAC - N, 12/27/2022]

16.2.6.10 EXPEDITED LICENSURE APPLICATION FOR MILITARY SERVICE MEMBERS AND VETERANS:

A. A candidate for expedited licensure under Section 61-1-34 NMSA 1978 must submit to the board, a complete application containing all the following:

(1) a completed and signed application form;

(2) proof of a current license in good standing from another jurisdiction, including a branch of the United States Armed Forces; and

(3) Submission of the following documentation:

(a) for military service member: copy of military orders;

(b) for spouse of military service members: copy of military service member's military orders and copy of marriage license;

(c) for spouses of deceased military service members: copy of decedent's DD214 and copy of marriage license;

(d) for dependent children of military service members: copy of military service member's orders listing dependent child, or a copy of military orders and one of the following: a copy of birth certificate, military service member's federal tax return or other governmental or judicial documentation establishing dependency;

(e) for veterans (retired or separated), proof of honorable discharge, such as a copy of DD form 214, DD form 215, DD form 256, DD form 257, NGB form 22, military ID card, driver's license or state ID card with a veteran's designation, or other documentation verifying honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted and board staff is in receipt of all of the materials, including documentation from third parties, required by Subsection A of 16.2.6.11 NMAC.

C. Upon receipt of a complete application, board staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant is not a qualified applicant as defined by this rule and has a potentially disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-14A-7 NMSA 1978:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged any initial licensing fees or renewal fees for the first three years of licensure with the board.

[16.2.6.10 NMAC - N, 12/27/2022]

16.2.6.11 EXPEDITED LICENSE DURATION AND RENEWAL:

A. An expedited license shall be valid for the same length of time as a regular initial license issued by the board.

B. A licensee holding an expedited license may apply for license renewal in the manner provided by the board's rules. However, if the licensee has not passed the NCCAOM in another jurisdiction, the licensee shall be required to take and pass the NCCAOM prior to renewing the license. Additionally, if the licensee has not passed any additional examinations as required by 16.2.4.10 NMAC, including the New Mexico clinical skills examination, the licensee shall be required to take and pass such examinations prior to renewing the license.

C. Upon renewal, the board shall issue a regular license to a licensee holding an expedited license granted under this rule.
[16.2.6.11 NMAC - N, 12/27/2022]

History of 16.2.6 NMAC:
Pre-NMAC History: None

History of Repealed Material:
16 NMAC 2.6, Reciprocal Licensing filed 4/16/1999 repealed effective 12/1/2001.
16.2.6 NMAC, Reciprocal Licensing filed 11/1/2001 repealed effective 12/27/2022.

Other:
16.2.6 NMAC, Reciprocal Licensing filed 11/1/2001, replaced by 16.2.6 NMAC, Expedited Licensing effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
ACUPUNCTURE AND ORIENTAL MEDICINE, BOARD OF

This is an amendment to 16.2.10 NMAC, Section 9, effective 12/27/2022.

16.2.10.9 FEES CHARGED:

A. All fees shall be paid by check, certified check or money order in US funds unless otherwise specified by rule.

B. No fees paid to the board shall be refunded.

C. The board shall charge the following fees:

(1) application for licensure: $525.00;

(2) application for [~~reciprocal~~] expedited licensure: $750.00;

(3) application for licensure by endorsement: $800.00;

(4) application for temporary licensure: $330.00;

(5) application for limited temporary license: $100.00;

(6) clinical skills examination, not including the cost of any nationally recognized examinations: $500.00;

(7) annual license renewal: $225.00;

(8) late license renewal: an additional $200.00;

(9) expired license renewal: an additional $350.00 plus the renewal and late fees;

(10) temporary license renewal: $100.00;

(11) application for a new annual approval or renewal of approval of an educational program, including the same program offered at multiple campuses: $450.00;

(12) late renewal of approval of an educational program: an additional $200.00;

(13) application for single instance approval of an educational program: $225.00;

(14) application for initial expanded practice certification: $100.00 per module;

(15) application for triennial expanded practice license renewal: an additional $200;

(16) late expanded practice license renewal: an additional $125.00 plus the renewal fee;

(17) expired expanded practice license renewal: an additional $100.00 plus the renewal and late fees;

(18) application for externship supervisor registration: $225.00;

(19) application for extern certification: $225.00;

(20) continuing education provider course approval application: $50.00;

(21) auricular detoxification specialist certification application: $50.00;

(22) auricular detoxification specialist certification renewal: $30.00;

(23) auricular detoxification specialist certification late renewal: $20.00;

(24) auricular detoxification specialist supervisor registration application: $50.00;

(25) auricular detoxification specialist training program approval application: $100.00;

(26) auricular detoxification specialist training program approval renewal: $50.00;

(27) treatment program approval application: $100.00;

(28) administrative fee for application for approval of an expanded practice educational course: $600.00;

(29) administrative fee for faculty change in an expanded practice course: $50.00;

(30) administrative fee for curriculum change in an expanded practice course: $150.00;

(31) renewal of expanded prescriptive authority course: $200.00;

(32) administrative fee for inactive license application: $125.00;

(33) administrative fee for inactive license renewal: $100.00;

(34) administrative fee for inactive license reinstatement application: $125.00;

(35) administrative fee for each duplicate license: $30.00;

(36) administrative fee for a single transcript or diploma from the former international institute of Chinese medicine, per copy: $50.00;

(37) administrative fees to cover the cost of photocopying, electronic data, lists and labels produced at the board office.

[11/3/1981…7/1/1996; A, 5/15/1999; A, 2-17-00; 16.2.10.9 NMAC - Rn, 16 NMAC 2.10.10, 10/22/2000; A, 1/1/2001; A, 8/13/2001; A, 3/2/2003; A, 2/15/2005; A, 9/25/2006; A, 11/28/2009; A, 11/28/2010; A, 2/8/2013; A, 3/2/2014; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
ACUPUNCTURE AND ORIENTAL MEDICINE, BOARD OF

This is an amendment of 16.2.12 NMAC, Sections 19 and 20, effective 12/27/2022.

16.2.12.19 FAILURE TO KEEP RECORDS: Pursuant to Paragraph (5) of Subsection A of Section 61-14A-17 NMSA 1978, a doctor of oriental medicine, temporary licensee, extern, educational program or applicant for approval of an educational program shall be guilty of unprofessional conduct who fails to keep written records reflecting the course of treatment of the patient for a period of at least seven years from the date of each service.
[16.2.12.19 NMAC - Rp, 16.2.12.19 NMAC, 2/11/2022; A, 12/27/2022]

16.2.12.20 FAILURE TO PROVIDE RECORDS TO PATIENT: Pursuant to the Act, Paragraph (5) of Subsection A of Section 61-14A-17 NMSA 1978, a doctor of oriental medicine, temporary licensee, extern, educational program or applicant for approval of an educational program shall be guilty of unprofessional conduct who fails to make available to a patient or client, upon request, copies of patient records in their possession, or under their control that have been prepared for and paid for by the patient or client. The patient records must be provided to the patient or client within 30 days of the written request, except as authorized or required by the Federal (Health Insurance Portability and Accountability Act (HIPAA).
[16.2.12.20 NMAC - Rp, 16.2.12.20 NMAC, 2/11/2022; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
BARBERS AND COSMETOLOGISTS, BOARD OF

The Regulation and Licensing Department, Board of Barbers and Cosmetologists approved, at its 12/12/2022 hearing, to repeal its rule 16.34.6 NMAC, Licensing by Reciprocity; Credit for Out-of-State Training, and replace with 16.34.6 NMAC Expedited Licensure, effective 12/27/2022.

The Regulation and Licensing Department, Board of Barbers and Cosmetologists approved, at its 12/12/2022 hearing, to repeal its rule 16.34.17 NMAC, Licensure for Military Service Members, Spouses, Dependent Children and Veterans, filed 4/15/2022, effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
BARBERS AND COSMETOLOGISTS, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 34 BARBERS AND COSMETOLOGISTS
PART 6 EXPEDITED LICENSURE

16.34.6.1 ISSUING AGENCY: New Mexico Board of Barbers and Cosmetologists
[16.34.6.1 NMAC - Rp 16.34.6.1 NMAC, 12/27/2022]

16.34.6.2 SCOPE: The provisions in Part 6 of Chapter 34 apply to all applicants for expedited licensure.
[16.34.6.2 NMAC - Rp, 16.34.6.2 NMAC, 12/27/2022]

16.34.6.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to the Barbers and Cosmetologists Act, Sections 61-17A-1 to -25 NMSA 1978.
[16.34.6.3 NMAC - Rp, 16.34.6.3 NMAC, 12/27/2022]

16.34.6.4 DURATION: Permanent.
[16.34.6.4 NMAC - Rp, 16.34.6.4 NMAC, 12/27/2022]

16.34.6.5 EFFECTIVE DATE: December 27, 2022, unless a later date is cited at the end of a section.
[16.34.6.5 NMAC - Rp, 16.34.6.5 NMAC, 12/27/2022]

16.34.6.6 OBJECTIVE: The objective of Part 6 is to promote, preserve and protect the public health, safety and welfare by regulating and setting professional standards for applicants for expedited licensure.
[16.34.6.6 NMAC - Rp, 16.34.6.6 NMAC, 12/27/2022]

16.34.6.7 DEFINITIONS:

A. "Eligible jurisdiction" means:

(1) any state or territory of the United States except those included in the list of disapproved licensing jurisdictions in 16.34.6.8 NMAC; and

(2) any foreign country included in 16.34.6.9 NMAC.

B. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

C. "Good standing" means a license or registration is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

D. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-2 NMSA 1978.

E. "Licensing fee" has the same meaning as defined in Paragraph (1) of Subsection E of Section 61-1-34 NMSA 1978.

F. "Military service member" has the same meaning as defined in Paragraph (2) of Subsection E of Section 61-1-34 NMSA 1978.

G. "Qualified applicant" means an applicant who:

(1) holds a current license in good standing in

another jurisdiction, provided that an applicant who is not a military service member or veteran must hold a current license in good standing in an eligible jurisdiction;

(2) does not have a disqualifying criminal conviction, as defined the board's rules; and

(3) is not subject to pending disciplinary action in New Mexico.

H. "Veteran" has the same meaning as defined in Paragraph (3) of Subsection E of Section 61-1-34 NMSA 1978.

[16.34.6.7 NMAC - Rp, 16.34.6.7 NMAC, 12/27/2022]

16.34.6.8 LIST OF DISAPPROVED LICENSING JURISDICTIONS; REASONS.

A. Barber License: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure as a barber under Section 61-17A-17 NMSA 1978 of the Barbers and Cosmetologists Act:

(1) Florida, New Jersey, New York, Oregon, and the U.S. Virgin Islands, on the grounds that the education and/or training requirements for licensure are not consistent with New Mexico's minimum requirements.

(2) American Samoa and the Northern Mariana Islands, on the grounds that these jurisdictions do not license, register, certify, or otherwise regulate this profession.

B. Cosmetologist license: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure as a cosmetologist under Section 61-17A-17 NMSA 1978of the Barbers and Cosmetologists Act:

(1) California, Florida, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Texas, and Puerto Rico on the grounds that the education and/or training requirements for licensure are not consistent with New Mexico's minimum requirements.

(2) Alaska and the Northern Mariana Islands, on the grounds that these jurisdictions do not license, register, certify, or otherwise regulate this profession.

(3) American Samoa, on the grounds that this jurisdiction will license applicants with a license from any U.S. state.

C. Manicurist/ pedicurist license: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure as a manicurist/pedicurist under Section 61-17A-17 NMSA 1978 of the Barbers and Cosmetologists Act:

(1) Alaska, Connecticut, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, Pennsylvania, and Virginia, on the grounds that the education and/or training requirements for licensure are not consistent with New Mexico's minimum requirements.

(2) American Samoa, Northern Mariana Islands, and Puerto Rico, on the grounds that these jurisdictions do not license, register, certify, or otherwise regulate this profession.

D. Esthetician license: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure as an esthetician under Section 61-17A-17 of the Barbers and Cosmetologists Act:

(1) Alaska, Florida, Massachusetts, Michigan, Oregon, Pennsylvania, South Carolina, and Wisconsin, on the grounds that the education and/or training requirements for licensure are not consistent with New Mexico's minimum requirements.

(2) American Samoa, the Northern Mariana Islands, and Puerto Rico, on the grounds that these jurisdictions do not license, register, certify, or otherwise regulate this profession.

E. Electrologist license: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure as an electrologist under Section 61-17A-17 NMSA 1978of the Barbers and Cosmetologists Act:

(1) American Samoa, Alabama, Alaska, Arizona, Colorado, Georgia, Kentucky, Minnesota, Mississippi, Missouri, New York, the Northern Mariana Islands, Pennsylvania, Puerto Rico, South Carolina, South Dakota, Texas, Virginia, Washington, West Virginia, and Wyoming, on the grounds that these jurisdictions do not license, register, certify, or otherwise regulate this profession.

(2) Guam, on the grounds that this jurisdiction will license applicants from a jurisdiction that allows estheticians to practice without regulation.

F. Instructor license: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure as an instructor under Section 61-17A-17 NMSA 1978 of the Barbers and Cosmetologists Act:

(1) Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, and Wyoming, on the grounds that the education and/or training requirements for licensure are not consistent with New Mexico's minimum requirements.

(2) American Samoa, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, on the grounds that licensure requirements, if any, cannot be determined.

G. Hairstylist license: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure as an esthetician under Section 61-17A-17 of the Barbers and Cosmetologists Act: Alabama, American Samoa, Arkansas, California, Delaware, District of Columbia, Florida, Guam, Idaho, Illinois, Indiana, Iowa, Kansas,

Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Northern Marina Islands, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, U.S. Virgin Islands, Vermont, Virginia, and Wisconsin, on the grounds that these jurisdictions do not license this profession.
[16.34.6.8 NMAC - Rp, 16.34.6.8 NMAC, 12/27/2022]

16.34.6.9 LIST OF APPROVED FOREIGN JURISDICTIONS: [RESERVED]
[16.34.6.9 NMAC - Repealed, 12/27/2022]

16.34.6.10 EXPEDITED LICENSURE APPLICATION:

A. A candidate for expedited licensure under Section 61-1-31.1 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) a completed and signed application form;

(2) proof of a current license in good standing in an eligible jurisdiction as defined in these rules; and

(3) payment of the required application fee.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-17A-21 NMSA 1978:

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) The license may not be issued within 30 days of submission of the complete application; and

(3) The board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.
[16.34.6.10 NMAC - Rp, 16.34.6.10 NMAC, 12/27/2022]

16.34.6.11 EXPEDITED LICENSURE APPLICATION FOR MILITARY SERVICE MEMBERS AND VETERANS:

A. A candidate for expedited licensure under Section 61-1-34 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application form;

(2) Proof of a current license in good standing in another jurisdiction, including a branch of the United States armed forces; and

(3) Submission of the following documentation:

(a) for military service member: a copy of military orders;

(b) for spouse of military service members: copy of military service member's military orders, and copy of marriage license;

(c) for spouses of deceased military service members: copy of decedent's DD 214 and copy of marriage license;

(d) for dependent children of military service members: a copy of military service member's orders listing dependent child, or a copy of military orders and one of the following: a copy of birth certificate, military service member's federal tax return or other governmental or judicial documentation establishing dependency;

(e) for veterans (retired or separated): proof of honorable discharge such as a copy of DD Form 214, DD Form 215, DD Form 256, DD Form 257, NGB Form 22, military ID card, a driver's license or state ID card with a veteran's designation, or other documentation verifying honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-17A-21 NMSA 1978:

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) The license may not be issued within 30 days of submission of the complete application; and

(3) The board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged a licensing fee for the first three years of licensure with the board.
[16.34.6.11 NMAC - Rp, 16.34.6.11 NMAC, 12/27/2022]

16.34.6.12 EXPEDITED LICENSE DURATION AND RENEWAL:

A. An expedited license shall be valid for the same length of time as a regular initial license issued by the board. Initial licenses, including expedited licenses, may be issued for a period greater than 12 months, but less than

twenty-four moths, in order to align the license expiration date with the board's renewal cycle.

B. A licensee holding an expedited license may apply for license renewal in the manner provided by the board's rules, provided that, upon renewal, the licensee shall be required to pass the practical and written examination conducted by the board as a prerequisite to license renewal.

C. Upon renewal, the board shall issue a regular license to a licensee holding an expedited license issued pursuant to these rules.

[16.34.6.12 NMAC - Rp, 16.34.6.12 NMAC, 12/27/2022]

HISTORY OF 16.34.6 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with State Records Center and Archives under:

Article IV, Licensing by Reciprocity: Credit for Out-of-State Training, 12/21/1981

Article IV, Licensing By Reciprocity: Credit for Out-of-State Training, 3/24/1989

Rule 4, Licensing By Reciprocity: Credit for Out-of-State Training, 3/8/1990

Rule 4, Licensing By Reciprocity: Credit for Out-of-State Training, 3/9/1992

Rule 5, Licensing By Reciprocity: Credit for Out-of-State Training, 10/19/1993

Rule 5, Licensing By Reciprocity: Credit for Out-of-State Training, 5/13/1994

Rule 5, Licensing By Reciprocity: Credit for Out-of-State Training, 8/12/1994

Rule 5, Licensing By Reciprocity: Credit for Out-of-State Training, 5/23/1995

BBE Rule 86-1, Board of Barber Examiners, Rules and Regulations - 1986, 6/27/1986

BBE Rule 87-1, NM Board of Barber Examiners, Rules and Regulations - 1987, 11/4/1987

BBE Rule 88-1, NM Board of Barber Examiners, Rules and Regulations - 1988, 10/4/1988

History of Repealed Material:

16 NMAC 34.6, Licensing By Reciprocity: Credit for Out-of-State Training - Repealed, 6/16/2001

16.34.6 NMAC, Licensing by Reciprocity: Credit for Out-of-State Training, filed 6/16/2001 was repealed 12/27/2022, and replaced by 16.34.6 NMAC, Expedited Licensure, effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT

BARBERS AND COSMETOLOGISTS, BOARD OF

This is an amendment to 16.34.1 NMAC, Sections 3, 6, 7, adding new Sections 8 through 10, effective 12/27/2022.

16.34.1.3 STATUTORY AUTHORITY: [~~Section 61-17A-2 NMSA1978 – Definitions~~] These rules are promulgated pursuant to the Barbers and Cosmetology Act, Sections 61-17A-1 to -25 NMSA 1978.

[16.34.1.3 NMAC - Rp 16 NMAC 34.1.3, 6/16/2001; A, 12/27/2022]

16.34.1.6 OBJECTIVE: [~~Pursuant to the Barbers and Cosmetologists Act this part establishes definitions.~~] The objective of Part 1 is to promote, preserve and protect the public health, safety and welfare by establishing regulations generally applicable to all licensees and professions subject to the Barbers and Cosmetology Act.

[16.34.1.6 NMAC - Rp 16 NMAC 34.1.6, 6/16/2001; A, 12/27/2022]

16.34.1.7 DEFINITIONS: As used in the Barbers and Cosmetologists Act:

A. "applicant" means a person who has applied for a license;

B. "apprentice" means a person enrolled in a barber apprenticeship program approved by and registered with the state apprenticeship agency;

C. "approval number" means the number assigned by the board to designate an approved provider;

D. "approved" means accepted as a provider by the board;

E. "barber" means a person, other than a student, who for compensation engages in barbering;

F. "barber apprenticeship" means an apprenticeship program registered with the state apprenticeship agency;

G. "barbering" means shaving or trimming the beard or cutting the hair, curling and waving, including permanent waving, straightening the hair, giving facial and scalp massage or treatments with oils, creams, lotions or other preparations, either by hand or mechanical appliances, shampooing, bleaching or dyeing the hair or applying tonics or applying cosmetic preparations, antiseptics, powders, oils, clays or lotions to the scalp, face, neck or upper part of the body, caring for and servicing wigs and hair pieces or removing of unwanted hair except by means of electrology;

H. "board" means the board of barbers and cosmetologists;

I. "booth establishment license" means a license required of an individual who rents space within another licensed establishment for the purpose of rendering licensed services as a separate, independent business;

J. "branch campus/ additional location" means an additional location that provides the same administrative services as the main campus, and offers at least one complete program entered into the programs offered at the main campus; a branch campus/additional location must be approved by the board as a separate school with a stand-alone license;

K. "clean or cleansing" means washing with liquid soap and water, detergent, antiseptics, or other adequate methods to remove all visible debris or residue. Cleansing is not disinfection;

L. "contact hour" means one contact hour equals

a minimum of 50 minutes of instruction;

M. "cosmetologist" means a person, other than a student, who for compensation engages in cosmetology;

N. "cosmetology" means arranging, dressing, curling, waving, cleansing, cutting, bleaching, coloring, straightening or similar work upon the hair of a person, whether by hand or through the use of chemistry or of mechanical or electrical apparatus or appliances, using cosmetic preparations, antiseptics, tonics, lotions or creams or massaging, cleansing, stimulating, manipulating, beautifying or performing similar work on the body of a person, manicuring and pedicuring the nails of a person, caring for and servicing wigs and hair pieces or removing of unwanted hair except by means of electrology. A cosmetologist shall not perform any type of shaving using a straight edge (or razor blade in any form) with or without a safety guard without obtaining appropriate licensure.

O. "current work experience" means verified work that has occurred within the previous five years;

P. "department" means the regulation and licensing department.

[~~P.~~] **Q. "disinfect or disinfection"** means the use of chemical agents (after cleaning) to destroy potentially dangerous pathogens on non-porous items;

[~~Q.~~] **R. "disinfectant"** means an EPA-registered bactericidal, virucidal and fungicidal chemical effective against pathogens of concern when used as directed on the manufacturer's label. For purposes of this rule alcohol and UV light boxes are not approved for disinfection;

[~~R.~~] **S. "electrologist"** means a person, other than a student, who for compensation removes hair from or destroys hair on the human body through the use of an electric current applied to the body with a needle-shaped electrode or probe;

[~~S.~~] **T. "electronic signature"** means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record;

[~~T.~~] **U. "enterprise"** means a business venture, firm, or organization;

[~~U.~~] **V. "expansion campus facility"** means any separate classroom or clinic used for educational purposes that is separate, detached and apart from the primary facility and main address; its purpose is to allow the licensed school to provide adequate space to train students who are enrolled through the primary facility and the expansion campus facility must be within a two-mile radius of the main campus;

[~~V.~~] **W. "establishment"** means an immobile beauty shop, barbershop, electrology clinic, salon or similar place of business in which cosmetology, barbering, eyebrow threading, hairstyling or electrolysis is performed;

[~~W.~~] **X. "esthetician"** means a person, other than a student, who for compensation uses cosmetic preparations, including makeup applications, antiseptics, powders, oils, clays or creams or massaging, cleansing, stimulating or manipulating the skin for the purpose of preserving the health and beauty of the skin and body or performing similar work on any part of the body of a person; using the term or title of "medical esthetician" is not allowable under the act; this term is misleading and could be deemed deceptive or fraudulent;

[~~X.~~] **Y. "eyebrow threading"** means a method of hair removal in which a thin thread is doubled, twisted and then rolled over areas of unwanted hair, removing the hair at the follicle level;

[~~Y.~~] **Z. "executive director"** means the director for the board;

[~~Z.~~] **AA. "expansion campus facility"** means any separate classroom or clinic used for educational purposes that is separate, detached and apart from the primary facility and main address; its purpose is to allow the licensed school to provide adequate space to train students who are enrolled through the primary facility and the expansion campus facility must be within a two-mile radius of the main campus;

[~~AA.~~] **BB. "externship"** means a student enrolled in any course licensed by this act may, at the school's option, participate in an externship program upon completion of seventy-five percent of the contracted course of study. The externship program would allow students to train in a licensed establishment for one day or up to eight hours per week until graduation. The training would be supervised by a designated salon licensee and would include any activity that is routine in a salon except for offering complete services on the public, applying any chemicals, or receiving any compensation;

[~~BB.~~] **CC. "hairstylist"** means a person, other than a student, who for compensation engages in hairstyling;

[~~CC.~~] **DD. "HSD"** means the New Mexico human services department;

[~~DD.~~] **EE. "hands-on training"** means student training on clients, students or models that includes active personal participation and practical experience necessary to gain knowledge. Training on mannequins is considered hands-on training;

[~~EE.~~] **FF. "instructor"** means a person licensed to teach in a school of cosmetology, barbering or in a school of electrology;

[~~FF.~~] **GG. "journey worker"** means a person who holds a current New Mexico barber license; is recognized by the sponsor as having attained and mastered a level of skill, abilities, and competencies in barbering and is authorized to provide related instruction and on-the-job training to licensed apprentices. The maximum allowable ratio of licensed apprentices to journey workers during on-the-job training is one to one;

[~~GG.~~] **HH. "jurisprudence exam"** means the examination given regarding the

laws, rules and regulations, which relate to the practice of barbers and cosmetologists in the state of New Mexico;

[~~HH.~~] II. **"license"** means a certificate, permit or other authorization to engage in each of the professions and occupations regulated by the boards enumerated in Subsection A of the act;

[~~II.~~] JJ. **"license in good standing"** refers to a current, valid, board-issued license with no restrictions placed on the license by the board;

[~~JJ.~~] KK. **"main campus"** means a school, which has been licensed by the board; any change in location of the main campus must comply with the procedures set forth in 16.34.8 NMAC of these rules; the main campus includes the primary facilities and any separate or detached expansion campus facility of the primary training site within a two-mile radius;

[~~KK.~~] LL. **"manicurist-esthetician"** means a person, other than a student, who for compensation performs work on the nails of a person, applies nail extensions or products to the nails for the purpose of strengthening or preserving the health and beauty of the hands or feet and who uses cosmetic preparations, including makeup applications, antiseptics, powders, oils, clays or creams or massaging, cleansing, stimulating or manipulating the skin for the purpose of preserving the health and beauty of the skin and body or performing similar work on any part of the body of a person;

[~~LL.~~] MM. **"manicurist-pedicurist"** means a person, other than a student, who for compensation performs work on the nails of a person, applies nail extensions or products to the nails for the purpose of strengthening or preserving the health and beauty of the hands or feet;

[~~MM.~~] NN. **"multi-use"** means non-porous instruments, items, equipment, implements or tools that must be cleaned and disinfected. The items must be disinfected by a complete immersion in an EPA registered, bactericidal, virucidal and fungicidal (formulated for hospitals) disinfectant that is mixed and used according to the manufacturer's directions. Non-porous items are the only items that can be disinfected;

[~~NN.~~] OO. **"non-porous"** means multi-use items such as metal, glass and plastic;

[~~OO.~~] PP. **"outreach enterprise"** means an independent mobile unit, or system of units, equipped with or carrying both professional and special equipment used by a professional licensee of this act to a site or premises for the purpose of providing professional services to the handicapped, restricted, homebound, impaired, incapacitated, delicate, or otherwise constrained client;

[~~PP.~~] QQ. **"sponsor"** means the sponsor in whose name the standards of apprenticeship will be registered with the state apprenticeship agency, and which will have the full responsibility for administration and operation of a barber apprenticeship program;

[~~QQ.~~] RR. **"provider"** means the person, firm, corporation, institution or agency approved to conduct or sponsor a continuing education program and ensure its integrity;

[~~**RR. "reciprocity" means a mutual exchange of privileges between states;**~~]

SS. "revoke a license" means to prohibit the conduct authorized by the license;

TT. "sanitation" means the maintenance of sanitary conditions to promote hygiene and the prevention of disease through the use of chemical agents or products;

UU. "school" means a public or private instructional facility approved by the board that teaches cosmetology or barbering;

VV. "single use items" means tools or supplies that come in contact with the public and are porous (made of anything other than plastic, metal or glass) cannot be disinfected (including, but not limited to: disposable razors, pedi-pads, emery boards, sponges, cotton pads, buffing blocks, toe separators, chamois, sandpaper drill bits, waxing strip, wood sticks, cotton balls, nail wipes, disposable towels, pumice stones, flip flops, and porous files, etc.) shall be disposed of immediately after use;

WW. "state apprenticeship agency" means the department of workforce solutions' state apprenticeship agency;

XX. "statement of compliance" means a certified statement from HSD stating that an applicant or licensee is in compliance with a judgment and order for support;

YY. "statement of non-compliance" means a certified statement from HSD stating that an applicant or licensee is not in compliance with a judgment and order for support;

ZZ. "sterilize or sterilization" means to eliminate all forms of bacteria or other microorganisms;

AAA. "student" means a person enrolled in a school to learn or be trained in cosmetology, barbering or electrolysis;

BBB. "supervising licensee" means licensee designated by the establishment owner or manager to act on behalf of the enterprise or establishment in the absence of the owner or manager. The supervising licensee must be licensed in all aspects of the activity being practiced in the enterprise or establishment;

CCC. "suspend a license" means to prohibit, for a stated period of time, the conduct authorized by the license; "suspend a license" also means to allow for a stated period of time the conduct authorized by the license subject to conditions that are reasonably related to the grounds for suspension;

DDD. "verified work experience" means work experience in the applicable discipline in a licensed establishment, enterprise or electrology clinic as verified by:

(1) certified and notarized statement by employer(s);

(2) certified and notarized statement by licensed co-worker(s);

(3) certified and notarized statement by client(s);

(4) copies of tax returns; or

(5) copies of W-2's;

[16.34.1.7 NMAC - Rp 16 NMAC 34.1.7, 6/16/2001; A, 7/16/2004; A, 10/4/2007; A, 12/17/2015; A, 10/29/2016; A, 7/14/2018; A, 12/27/2022]

16.34.1.8 MISSION OF THE BOARD: The mission of the board is to promote , preserve and protect the public health, safety and welfare by regulating the practices of barbering, cosmetology, electrology, esthetics, hairstyling, manicuring, and pedicuring in New Mexico. The board is not an advocacy organization but is instead a regulatory body responsible at all times and in all situations for acting in the interest of the public.
[16.34.1.8 NMAC – N, 12/27/2022]

16.34.1.9 AUTHORITY OF THE REGULATION AND LICENSING DEPARTMENT: Not withstanding any other provisions under these rules, the department shall have the authority to:

A. process and issue licenses to applicants who meet the requirements of the Barbers and Cosmetology Act and board rules;

B. investigate persons engaging in practices that may violate the provisions of the Barbers and Cosmetology Act and report results of investigation to the board;

C. approve the selection of and supervise primary staff assigned to the board;

D. carry out the Operations of the board to include budgetary expenditures;

E. maintain records, including financial records; and

F. keep a licensee record in which the names, addresses and license numbers of all licensees shall be recorded together with a record of all license renewals, suspensions and revocations.
[19.34.1.9 NMAC - N, 12/27/2022]

16.34.1.10 INFORMATIONAL OBLIGATIONS OF LICENSEES:

A. Contact information:

(1) A licensee is obligated to maintain current and accurate contact information on file with the department.

(2) A licensee shall notify the department within 30 days of a change of the licensee's contact information.

(3) Failure to disclose a change of mailing or residential address may constitute grounds for disciplinary action.

(4) For the purpose of this rule, "contact information" means the licensee's mailing address, residential address, email address, and telephone number.

B. Names and addresses of place of business:

(1) A licensee is obligated to maintain the current and accurate name and address of the licensee's place of business on file with the department.

(2) A licensee shall notify the department within 30 days of any changes in the name and address of the licensee's place of business.

(3) Failure to disclose a change of the name and mailing address of the licensee's employer may constitute grounds for disciplinary action.
[16.34.10 NMAC - N, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
BARBERS AND COSMETOLOGISTS, BOARD OF

This is an amendment to 16.34.2 NMAC, Sections 3, 11, 12, effective 12/27/2022.

16.34.2.3 STATUTORY AUTHORITY: [~~Section 61-17A-5 - License required to provide services for compensation directly or indirectly.~~] These rules are promulgated pursuant to the Barbers and Cosmetology Act, Sections 61-17A-1 to -25 NMSA 1978.
[16.34.2.3 NMAC - Rp 16 NMAC 34.2.3, 6/16/2001; A, 12/27/2022]

16.34.2.11 [~~PROVISIONS FOR EMERGENCY LICENSURE:~~

~~**A.** Barbers, cosmetologists, hairstylist, manicurists/pedicurists, estheticians, electrologists, and instructors currently licensed and in good standing, or otherwise meeting the requirements for New Mexico licensure in a state in which a federal disaster has been declared, may be licensed in New Mexico during the four months following the declared disaster upon satisfying the following requirements:~~

~~**(1)** receipt by the board of a completed application which has been signed and which is accompanied by proof of identity, which may include a copy of a driver's license, passport or other photo identification issued by a governmental entity;~~

~~**(2)** refer to 16.34.2.8 NMAC, general licensing procedures; 16.34.5.8 NMAC, general licensure requirements; and 16.34.6.8 NMAC, reciprocity;~~

~~**(3)** other required verification will be that the board office will contact the applicant's prior licensing board by email, mail, or telephone for confirmation of what is provided by the applicant.~~

~~**B.** The board may waive the following requirements for licensure:~~

~~**(1)** application fees;~~

~~**(2)** specific forms or documentation required, on an individual case by case basis, under 16.34.2.8, 16.34.5.8, and 16.34.6.8 NMAC if the applicant is unable to obtain documentation from the federal declared disaster areas.~~

~~**C.** Nothing in this section shall constitute a waiver of the requirements for licensure contained~~

~~in 16.34.2.8, 16.34.5.8, and 16.34.6.8 NMAC.~~

~~**D.** Licenses issued under (the emergency provision) shall be issued for a period of one year of less following the date of issuance, unless the board or an agent of the board approves a renewal application. Application for renewal shall be made on or before one year following the date of issue to avoid late renewal fees. The board reserves the right to request additional documentation, including but not limited to, recommendation forms and work experience verification forms prior to approving license renewal.~~]

[RESERVED]

[16.34.2.11 NMAC - N/E, 11/10/2005; A, 7/14/2018; Repealed, 12/27/2022]

16.34.2.12 [~~**EMERGENCY LICENSE TERMINATION:**~~

~~**A.** The emergency license shall terminate upon the following circumstances:~~

~~**(1)** the issuance of a permanent license under section 16.34.2.8, 16.37.5.8, and 16.34.6.8 NMAC; or~~

~~**(2)** proof that the emergency license holder has engaged in fraud deceit, misrepresentation in procuring or attempting to procure a license under this section.~~

~~**B.** Termination of an emergency license shall not preclude application for permanent licensure.~~]

[RESERVED]

[16.34.2.12 NMAC - N/E, 11/10/2005; Repealed, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
BARBERS AND COSMETOLOGISTS, BOARD OF

This is an amendment to 16.34.5 NMAC, Section 8, effective 12/27/2022.

16.34.5.8 GENERAL LICENSURE REQUIREMENTS:

A. Any person is eligible to be registered as a practitioner and is qualified to receive a license as a registered barber, cosmetologist, hairstylist, manicurist, esthetician, manicurist/esthetician, or electrologist who submits proof that the applicant:

(1) is at least 17 years of age;

(2) [~~has an education equivalent to the completion of the second year of high school;~~

~~(3)~~] has completed the course of study for the license in a licensed school within the preceding 12 months; or for a barber license, proof that the applicant has either completed the course of study in a licensed school within the preceding 12 months or has successfully completed a barber apprenticeship program registered by the state apprenticeship agency within the preceding 12 months;

[**~~(4)~~] (3)** has paid the required fees as set forth in these rules; and

[**~~(5)~~] (4)** has passed the practical and written examination conducted by the board.

B. Any person is eligible for initial registration or re-registration as an instructor and is qualified to receive a license as an instructor who submits proof that the applicant has met all the above requirements and in addition:

(1) for barber instructors, has an education equivalent to the completion of four years of high school; and

(2) holds a current license in New Mexico as a practitioner in the field in which the applicant is seeking licensure as an instructor.

C. Applicants who have not completed a course of study equivalent to the license for which he/she is applying may submit notarized letters of employment or employment records to prove licensed, current, verified work experience. Six full months of work experience will equal 150 hours of training. Work experience less than six full months will not be considered toward training hours.

D. Applications are valid for one year from date of receipt.

E. All application fees are non-refundable.

[16.34.5.8 NMAC - Rp 16 NMAC 34.5.8, 6/16/2001; A, 7/16/2004; A, 12/17/2015; A, 10/29/2016; A, 7/14/2018; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
BARBERS AND COSMETOLOGISTS, BOARD OF

This is an amendment to 16.34.8 NMAC, Section 13, effective 12/27/2022.

16.34.8.13 REGULATIONS CONCERNING STUDENTS:

A. Student registration

(1) When a school receives an application from a prospective student, it shall promptly notify the student of the registration requirements of the board.

(2) It shall constitute a violation of the rules, within the meaning of the act, for a school to engage in failure to transmit student registration documents and fees in a timely fashion to the board pursuant to Subsection G of 16.34.15.8 NMAC, wherein fines will be imposed.

(3) It shall be the responsibility of the prospective student to comply with the registration requirements by the first day [~~he/she~~] the student attends class for credit. Failure to do so may result in loss of hours earned prior to proper registration.

(4) No school shall allow a student to attend class for credit until the student has complied with the registration requirements:

(a) Applicants for the barber, cosmetology, hairstylist, manicure/pedicure, esthetician, electrologist, and manicure/esthetician courses must

be at least 16 years of age [~~and have successfully completed two years of high school or the equivalent.~~]

(b) Applicants for the instructor course for barbers must be at least 17 years of age and have successfully completed four years of high school or the equivalent.

(5) Acceptable proof of age and education requirements as follows:

(a) Proof of age includes a copy of a birth certificate, a driver's license or a state issued identification card, or a baptismal certificate.

(b) Proof of two years of secondary education includes a high school diploma, a G.E.D. certificate or transcript of G.E.D. test scores, a sealed letter from the high school attended, a copy of the high school transcript showing all required grades have been passed, a letter from the G.E.D. testing facility stating that the G.E.D. test has been passed, or any other test approved by the United States department of education for the purpose of determining an applicant's ability to benefit, providing that documentation of grade equivalency is established by the test publisher and the required grade level for the course of study has been achieved.

(c) The board, or its executive director, may accept as proof of secondary education the applicant's notarized statement that the applicant has completed the required secondary education, but has been unable to obtain documentary proof of that from a foreign nation. A notarized statement will not be accepted for students who have completed the secondary education in the United States.

(6) Evidence of compliance with the foregoing requirements shall accompany the application for registration form provided by the board.

(7) Upon receipt of a complete student registration form and applicable fee, which shall be received in the board office within 15 days of the date of registration, the board office will then issue a student permit and a permit number. The student permit authorizes the holder to practice course related skills in an approved school on the public only after successful completion of fifteen percent of the program. In addition, the student permit also authorizes the student to participate in the student externship program pursuant to 16.34.8.17 NMAC of these rules. A photograph of the student (front view, head only, at least one and one-half inches by one and one-half inches) shall be attached to the permit. The permit shall be displayed in a binder in the school in which the student is enrolled and open to review by the state inspector or other board designee. Student permits are the property of the board and must be returned to the board by the school upon termination of the student's enrollment.

(8) If inspection of the student permits and school records determines that students are attending class without being properly registered with the board, the student may be denied the hours previously accrued and the school will be reported to the board for disciplinary action.

B. Student transfers/re-entries

(1) Any previously registered student desiring to transfer to another school, or re-enter the previous school shall submit a new registration form and required fees to the board. Students transferring schools as a result of a school closure shall submit a new registration form but are not required to pay a re-registration fee. Students attending a school, which undergoes a change of ownership, are not required to re-register with the board.

(2) Any student desiring to re-enter school must submit proof of the successfully completed previous training in order to receive credit for it.

(3) A student enrolled in any course may withdraw and transfer hours or equivalent credit acquired to another course not to exceed the amount of hours or equivalent credit of each subject within the new course curriculum requirements. Appropriate termination notices and course registration documents must be submitted to the board office when a student transfers to another course.

(4) Students enrolled in the cosmetology curriculum may take the examination for one of the specialty courses at which time the school certifies that the student has completed the requirements for the course in which the student seeks licensure. All other requirements for examination must also be met. The student may continue to attend classes in the cosmetology course. However, if licensure is obtained in any specialty course and the student continues attending classes in the cosmetology course, [~~he/she~~] students cannot perform any services on the public in the school for which the individual is now licensed.

C. Records of student academic progress

(1) Schools shall keep records of academic progress for each student and these records shall be open for inspection by members of the board or its designees.

(2) Schools will designate in the enrollment contract and other consumer information, all requirements for withdrawal or graduation. When all requirements have been met, the school must return the student's permit to the board, and submit a sealed official transcript of training to the board and to the student showing that course requirements for graduation have been met. The board recognizes for transfer, hours or equivalent credits reported on the official transcript of training. Circumstances regarding transfer of or approval of student hours may be brought to the board on an individual basis for special consideration by the board. The board may, in its discretion, recognize hours or equivalent credit or partial hours or

partial credit for transfer when an official transcript of training has not been submitted by the school.

(3) If a student terminates his/her enrollment status without meeting all withdrawal or graduation requirements, the school in which [~~he/she~~] the student was enrolled shall notify the board of termination in writing within 30 days of the student's formal termination date using the format prescribed by the board, and return the student's permit.

(3) If a student terminates [~~he/she~~] their enrollment status without meeting all withdrawal or graduation requirements, the school in which [~~he/she~~] student was enrolled shall notify the board of termination in writing within thirty days of the student's formal termination date using the format prescribed by the board, and return the student's permit.

(4) Schools offering clock hour training shall define its attendance requirements to include one hundred percent attendance for the course length for licensure or may allow excused absences for no more than ten percent of the course length for satisfactory course completion.

(a) student attendance policies are applied uniformly and fairly;

(b) attendance policies give appropriate credit for all hours attended;

(c) schools shall not adjust attendance hours of students whether hours are added, as a reward, or deducted, as a penalty;

(d) the school shall report actual hours attended by the student or shall round the hours to the nearest half hour (i.e. if a student attended 44 minutes past the hour, the school would report the previous half hour; if a student attended 45 minutes past the hour, the school would report the next hour);

(e) the school must maintain attendance records for each student to verify that the minimum attendance standard set forth by the board is being met; and

(f) in cases where schools are authorized to offer training via distance learning methods, the school establish standards for converting competencies achieved to clock or credit hours.

(5) To be considered a graduate, a student must have completed the course scheduled for completion and met the minimum attendance standard (or ninety percent) of the established course of study and all other academic and evaluation factors established by the school. Therefore, in addition to completion of the required hours, the student must have satisfactorily completed the practical and theoretical curriculum requirements set forth by the school. Those requirements must include documentation that the student has satisfactorily completed each unit of study prescribed by the board in the applicable course of study. The excused absences do not allow a student to accelerate in their course of study. Even though they may limit excused absences, they will not be allowed to sit for the state licensing examination until the number of hours, prescribed by the board for the applicable course of study, have elapsed.

(6) If a student is required OR allowed by the school to train more than the scheduled hours in a class day, [~~he/she~~] students must be given credit for the additional time in the appropriate subject. Schools have full discretion in setting forth class schedules for each course offered as long as minimum requirements for graduation meet the board standards.

(7) Students may not be called from a scheduled theory class to perform services on the public.

(8) Schools expressing academic measurement in terms of credit hours shall set forth requirements for each unit of study within a course or program which ensures that required levels of competency or skills ability have been met. Such schools must award appropriate credit for each unit of study completed satisfactorily. Records of the students' academic progress within the course of study must be maintained for all students.

(9) The school shall provide a catalog to prospective students containing enough information to permit an informed choice among training opportunities and institutions. Catalogs which comply with the school's accrediting agency will be deemed to comply with this rule.

(10) Schools must comply with the Family Education Right to Privacy Act and must guarantee the rights of students to have access to their cumulative records and provide for proper supervision and interpretation of student records when reviewed.

(11) Schools and students shall enter into a signed written agreement which fully and accurately reflects the contractual rights and obligations of the parties, particularly with regard to suspension, expulsion, refunds, tuition and fees, withdrawal and graduation requirements. Contracts which comply with the school's accrediting agency will be deemed in compliance with this rule.

D. Records regarding state board examinations: Each school shall disclose to prospective students its annual statistics regarding the school's state examination pass rate. The board or its designee will send a letter to each school after each examination containing the result information on each student, which will serve as the source documentation for calculating the disclosed statistics.

[16.34.8.13 NMAC - Rp 16 NMAC 34.8.13, 6/16/2001; A, 7/16/2004; A, 10/4/2007; A, 12/17/2015; A, 7/14/2018; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT

BARBERS AND COSMETOLOGISTS, BOARD OF

This is an amendment to 16.34.11 NMAC, Sections 8, 9, effective 12/27/2022.

16.34.11.8 VIOLATIONS BY LICENSEES:

A. When the board becomes aware of information or evidence tending to indicate that a violation of the act or these rules has been or is being committed by a licensee or student, it will review the matter and take appropriate action, or it may refer the matter to an informal subcommittee for review and recommendation, or it may make such investigation as it deems appropriate.

B. If an investigation is made, upon conclusion that a violation has occurred, the board shall:

(1) take no further action;

(2) issue a notice of contemplated action (NCA) under the Uniform Licensing Act;

(3) invite the parties to an informal conference with the board or the board's designee to aid in the board's resolution of the matter;

(4) issue a cease and desist order in accordance with the Uniform Licensing Act if the board determines that conditions within the establishment present a substantial danger of illness, serious physical harm or death to customers who might patronize the establishment;

(5) file a formal complaint with a court of appropriate jurisdiction; or

(6) issue or direct the board's executive director to issue a letter of warning, a statement of what the board believes must be done to come into compliance with the act or these rules or a similar communication.

[16.34.11.8 NMAC - Rp 16 NMAC 34.11.8, 6/16/2001; A, 7/16/2004; A, 12/17/2015; A, 12/27/2022]

16.34.11.9 VIOLATION OF SANITATION AND SAFETY REQUIREMENTS:

A. If an establishment or enterprise fails the second inspection (re-inspection):

(1) an administrative fee pursuant to 16.34.15.8 NMAC;

(2) a cease and desist order will be served in accordance with the Uniform Licensing Act;

(3) a re-inspection fee of up to $200.00 will be assessed, at the time of the re-inspection.

C. If an establishment or enterprise fails the third inspection (second re-inspection):

(1) the inspector will file a complaint;

(2) a re-inspection fee of $200.00 will be assessed, at the time of the re-inspection;

(3) a cease and desist will be served in accordance with the Uniform Licensing Act.

[16.34.11.9 NMAC - Rp 16 NMAC 34.11.9, 6/16/2001; Repealed, 10/4/2007; N, 7/14/2018; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT

BARBERS AND COSMETOLOGISTS, BOARD OF

This is an amendment to 16.34.14 NMAC, Sections 3, 6, 8, effective 12/27/2022.

16.34.14.3 STATUTORY AUTHORITY: [~~The Barbers and Cosmetologists Act, Sections 61-17A-7 and 61-17A-16 NMSA 1978. This authorizes the board to establish fees.~~] These rules are promulgated pursuant to the Barbers and Cosmetologists Act, Sections 61-17A-1 to -25 NMSA 1978.

[16.34.14.3 NMAC - Rp 16 NMAC 34.14.3, 6/16/2001; A, 12/27/2022]

16.34.14.6 OBJECTIVE: [~~Pursuant to the Barbers and Cosmetologists Act this part itemizes all fees.~~] The objective of Part 14 is to promote, preserve and protect the public health, safety and welfare by setting fees to be charged by the board or department where applicable.

[16.34.14.6 NMAC - Rp 16 NMAC 34.14.6, 6/16/2001; A, 12/27/2022]

16.34.14.8 FEES: [~~The fees for examination, original licensure and annual renewal, licensure by reciprocity and special fees are as follows:~~] The board or department, where applicable, may charge the following fees:

A. Enterprise or establishment license (original): $200.00

B. Enterprise or establishment license (renewal): $50.00

C. Booth establishment license (original): $200.00

D. Booth establishment license (renewal): $50.00

E. School license (original and renewal): $500.00

F. Relocation of a school: $185.00

G. Barber license (original and renewal): $100.00

H. Cosmetologist license (original and renewal): $100.00

I. Hairstylist license (original and renewal): $50.00

J. Manicurist/ pedicurist license (original and renewal): $100.00

K. Manicurist/ esthetician license (original and renewal): $100.00

L. Electrologist license (original and renewal): $100.00

M. Esthetician license (original and renewal): $100.00

N. Instructor license (original and renewal): $100.00

O. ~~Reciprocity~~ Expedited license (original): $150.00

P. Administrative fee (other examination administrative costs): a maximum of $100.00

Q. Administrative fee (lists on disks): $95.00

R. Administrative fee (relocation of establishments, etc.): $25.00

S. Examinations and re-examinations all licenses except instructor: a maximum of $100.00

T. Instructor examination and re-examination: a maximum of $100.00

U. Duplicate licenses: $25.00

V. Student permit license: $25.00

W. Barber apprentice license: $25.00

X. Late fee: $40.00

Y. Provider approval, initial and renewal: $50.00

Z. Re-inspection fee: up to $200.00.

[16.34.14.8 NMAC - Rp 16 NMAC 34.14.8, 6/16/2001; A, 7/16/2004; A, 10/04/2007; A, 4/12/2010; A, 10/29/2016; A, 7/14/2018; A, 4/15/2022; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
BODY ART PRACTITIONERS, BOARD OF

The Regulation and Licensing Department, Board of Body Art Practitioners approved, at its 12/12/2022 hearing, to repeal its rule 16.36.8 NMAC, Expedited Licensure for Military Service Members and Veterans, and replace with 16.36.8 Expedited Licensure effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
BODY ART PRACTITIONERS, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 36 BODY ARTISTS AND OPERATORS
PART 8 EXPEDITED LICENSURE

16.36.8.1 ISSUING AGENCY: The New Mexico Board of Body Art Practitioners.
[16.36.8.1 NMAC – Rp, 16.36.8.1 NMAC 12/27/2022]

16.36.8.2 SCOPE: This provisions of Part 8 of Chapter 36 apply to all for expedited licensure under the Body Art Safe Practice Act, Sections 61-17B-1 to -18 NMSA 1978, and the Board rules promulgated pursuant to the Act.
[16.36.8.2 NMAC – Rp, 16.36.8.2 NMAC 12/27/2022]

16.36.8.3 STATUTORY AUTHORITY: This part is promulgated pursuant to the Body Art Safe Practices Act, specifically Subsection D of Sections 61-17B-5 NMSA 1978 of the Act, and Sections 61-1-31.1 NMSA 1978 and Sections 61-1-34 NMSA 1978 of the Uniform Licensing Act, Sections 61-1-1 to -37 NMSA 1978..
[16.36.8.3 NMAC – Rp, 16.36.8.3 NMAC 12/27/2022]

16.36.8.4 DURATION: Permanent
[16.36.8.4 NMAC – Rp, 16.36.8.4 NMAC 12/27/2022]

16.36.8.5 EFFECTIVE DATE: December 27, 2022, unless a later date is cited at the end of a section.
[16.36.8.5 NMAC – Rp, 16.36.8.5 NMAC 12/27/2022]

16.36.8.6 OBJECTIVE: The purpose Part 8 is to promote and protect the public health, safety and welfare by regulating and setting professional standards for applicants for expedited licensure.
[16.36.8.6 NMAC – Rp, 16.36.8.6 NMAC 12/27/2022]

16.36.2.7 DEFINITIONS:

A. "Eligible Licensing Jurisdiction" means:

(1) any state or territory of the United States and the District of Columbia, except those jurisdictions included in the list of disapproved licensing jurisdictions under 16.36.8.8 NMAC; and

(2) any foreign country included in the list of approved licensing jurisdictions under 16.6.8.9 NMAC.

B. "Expedited License" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

C. "Good Standing" means an occupational or professional license is active and not expired suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a license or registrant under the authority of the license.

D. "License" has the same meaning as defined in Subsection E of Section 61-1-2 NMSA 1978.

E. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-34 NMSA 1978.

F. "Licensing fee" has he same meaning as defined in Paragraph (2) of Subsection E of Section 61-1-34 NMSA 1978.

G. "Military service member" has the same meaning as defined in Paragraph (2) of Subsection E of Section 61-1-34 NMSA 1978.

H. Military orders" means official military orders, including orders from separation or retirement, or any notification, certification, or verification from the service member's commanding officer, with respect to the service member's current or future military duty status.

I. "Qualified applicant" means a person who has applied for an occupational or professional license who:

(1) holds a current license in good standing issued in an eligible licensing jurisdiction as defined in subsection A of this section, including a branch of the armed forces of the United States:

(2) does not have a disqualified criminal conviction listed in the Board's rules as published in the New Mexico Administrative Code; and

(3) is not the subject of a pending disciplinary action in the State of New Mexico.

J. "Regular License" has the same meaning as defined in Subsection G of Section 61-1-2 NMSA 1978.

K. "Veteran" has the same meaning as defined in Paragraph (3) of Subsection E of Section 61-1-34 NMSA 1978.

[16.36.8.7 NMAC – Rp, 16.36.8.7 NMAC 12/27/2022]

16.36.8.8 LIST OF DISAPPROVED LICENSING JURISDICTIONS:

A. Applicants for licensure as a permanent cosmetics practitioner in the following states and territories of the United States shall not be eligible for expedited licensure under Subsection D of Sections 61-17B-5 NMSA 1978.

(1) The following jurisdictions on the grounds that the training and examination requirements are not, or cannot be determined to be, consistent with New Mexico:

(a) Alabama;

(b) Arizona;

(c) California;

(d) Colorado;

(e) Connecticut;

(f) Delaware;

(g) Florida;

(h) Georgia;

(i) Hawaii;

(j) Idaho;

(k) Illinois;

(l) Indiana;

(m) Iowa;

(n) Kentucky;

(o) Louisiana;

(p) Maine;

(q) Maryland;

(r) Massachusetts;

(s) Michigan;

(t) Montana;

(u) Nebraska;

(v) Nevada;

(w) New York;

(x) North Carolina;

(y) North Dakota;

(z) Ohio;

(aa) Pennsylvania;

(bb) Rhode Island;

(cc) South Carolina;

(dd) South Dakota;

(ee) Texas;

(ff) Utah;

(gg) Washington;

(hh) West Virginia;

(ii) Wisconsin;

(jj) Wyoming;

(kk) American Samoa;

(ll) Guam;

(mm) Northern Mariana Islands;

(nn) Puerto Rico; and

(oo) U.S Virgin Islands.

(2) Licensed permanent cosmetics practitioners in the following jurisdictions are eligible for expedited licensure: Alaska, Arkansas, District of Columbia, Kansas, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, Oklahoma, Oregon, Tennessee, Vermont, and Virginia.

B. Applicants for licensure as a body piercing-scarification practitioner licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Subsection D of Sections 61-17B-5 NMSA 1978.

(1) The following jurisdictions on the grounds that the training and examination requirements are not, or cannot be determined to be, consistent with New Mexico:

(a) Alabama;

(b) Arizona;

(c) California;

(d) Colorado;

(e) Connecticut;

(f) Delaware;

(g) Florida;

(h) Georgia;

(i) Hawaii;

(j) Idaho;

(k) Illinois;

(l) Indiana;

(m) Iowa;

(n) Kentucky;

(o) Louisiana;

(p) Maine;

(q) Maryland;

(r) Massachusetts;

(s) Michigan;

(t) Nebraska;

(u) Nevada;

(v) New York;

(w) North Carolina;

(x) North Dakota;

(y) Ohio;

(z) Oregon;

(aa) Pennsylvania;

(bb) Rhode Island;

(cc) South Carolina;

(dd) South Dakota;

(ee) Texas;

(ff) Utah;

(gg) Washington;

(hh) West Virginia;

(ii) Wisconsin;

(jj) Wyoming;

(kk) American Samoa;

(ll) Guam;

(mm) Northern Mariana Islands;

(nn) Puerto Rico; and

(oo) U.S Virgin Islands.

(2) Licensed body piercing-scarification practitioners in the following jurisdictions are eligible for expedited licensure: Alaska, Arkansas, District of Columbia, Kansas, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Jersey, Oklahoma, Tennessee, Vermont, and Virginia.

C. Applicants for licensure as a tattoo artist licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Subsection D of Sections 61-17B-5 NMSA 1978.

(1) The following jurisdictions on the grounds that the training and examination requirements are not, or cannot be determined to be, consistent with New Mexico:

(a) Alabama;

(b) Arizona;

(c) California;

(d) Colorado;

(e) Delaware;

(f) Florida;

(g) Georgia;

(h) Hawaii;

(i) Idaho;

(j) Illinois;

(k) Indiana;

(l) Iowa;

(m) Kentucky;

(n) Louisiana;

(o) Maine;

(p) Maryland;

(q) Massachusetts;

(r) Michigan;

(s) Nebraska;

(t) Nevada;

(u) New York;

(v) North Carolina;

(w) North Dakota;

(x) Ohio;

(y) Pennsylvania;

(z) Rhode Island;

(aa) South Carolina;

(bb) South Dakota;

(cc) Texas;

(dd) Utah;

(ee) Washington;

(ff) West Virginia;

(gg) Wisconsin;

(hh) Wyoming;

(ii) American Samoa;

(jj) Guam;

(kk) Northern Mariana Islands;

(ll) Puerto Rico; and

(mm) U.S Virgin Islands.

(2) Licensed tattoo artists in the following jurisdictions are eligible for expedited licensure: Alaska, Arkansas, Connecticut, District of Columbia, Kansas, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Jersey, Oklahoma, Oregon, Tennessee, Vermont, and Virginia.

[16.36.8.8 NMAC – Rp, 16.36.8.8 NMAC 12/27/2022]

16.36.8.9 LIST APPROVED FOREIGN JURISDICTIONS: [RESERVED]

[16.36.8.9 NMAC – Rp, 16.36.8.9 NMAC 12/27/2022]

16.36.8.10 POSTING OF LISTS; ANNUAL REVIEW OF LISTS:

A. The lists of disapproved and approved licensing jurisdictions shall be posted on the board's website.

B. The lists of shall be reviewed annually by the board to determine whether amendments to this part are warranted.

[16.36.8.10 NMAC – Rp, 16.36.8.10 NMAC 12/27/2022]

16.36.8.11 EXPEDITED LICENSURE APPLICATION:

A. An applicant for expedited licensure under Section 61-1-31.1 NMSA 1978 shall submit the to the board a complete application containing all the following:

(1) completed and signed application form;

(2) proof of current licensure in an eligible jurisdiction;

(3) certificate of good standing for the license held by the applicant in the eligible jurisdiction;

(4) current bloodborne pathogens certification;

(5) current CPR/First Aid certification; and

(6) payment of the required application fee.

B. An expedited license application shall not be deemed complete until the applicant has submitted and the board is in receipt of all the materials required by subsection A, including documentation form third parties.

C. Upon receipt of a complete application the board staff shall process the application and issue an expedited license to a qualified applicant within 30 days.

D. If the applicant has a disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Sections 16.36.4.8 NMAC:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at it's next available meeting;

(2) the license may not be issued within 30 days of submission of the complete application;

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

[16.36.8.11 NMAC – Rp, 16.36.8.11 NMAC 12/27/2022]

16.36.8.12 EXPEDITED LICENSURE APPLICATION FOR MILITARY SERVICE MEMBERS AND VETERANS:

A. An applicant for expedited licensure under Section 61-1-34 NMSA 1978 shall submit to the board a complete application containing the following:

(1) a completed and signed application form;

(2) proof of current licensure from another jurisdiction;

(3) certificate of good standing for the license held by the applicant in another jurisdiction. Including a branch of the United States armed forces;

(4) current bloodborne pathogens certification;

(5) current CPR/First Aid certification; and

(6) Submission of the following documentation:

(a) for a military service member, a copy of the service member's military orders;

(b) for a spouse of a military service member, a copy of the service member's military orders and a copy of the parties' marriage license;

(c) for a spouse of a deceased military service member, a copy of the decedent's DD Form 214 and a copy of marriage license;

(d) For dependent children of military service members: a copy of military service members orders listing dependent child, or a copy of military orders and one of the following: a copy of birth certificate, military service federal tax return or other governmental or judicial documentation establishing dependency;

(e) for veterans, retired or separated, proof of honorable discharge, a copy of DD From 214, DD Form 215, DD From 265, DD Form 257, NGB Form 22, military ID card, a state-issued driver's license or identification card with veteran's designation, a veteran ID card (VIC) issued by the U.S Department of Veteran's Affairs, or other documentation verifying the veteran's honorable discharge from military service.

B. An expedited license application shall not be deemed complete until the applicant has submitted and the board staff is in receipt of, including documentation from third parties, as required by subsection A of this section.

C. Upon receipt of a complete application the board's staff shall process the application and issue an expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualified criminal conviction or the board may have other cause to deny the application pursuant to Section 61-5A-21 NMSA 1978:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at it's next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged a licensing fee for the first three years of licensure with the board.

[16.36.8.12 NMAC – Rp, 16.36.8.12 NMAC 12/27/2022]

16.36.8.13 EXPEDITED LICENSE DURATION AND RENEWAL:

A. An expedited license issued to an applicant under Subsection D of Section 61-17B-5 NMSA 1978 shall be a provisional license valid for one year from date of issuance. Initial licenses, including expedited licenses, may be issued

for a period greater than 12 months, but less than 24 months, in order to align the license expiration date with the board's renewal cycle.

B. A license holding an expedited license may apply for license renewal in the manner provided by the board's rules, provided that upon renewal, the licensee must also satisfy the following examination requirements:

(1) the license shall be required to pass the New Mexico Jurisprudence exam.

C. Upon renewal, the board shall issue a regular license to a licensee holding an expedited license issued pursuant to these rules.

[16.36.8.13 NMAC – Rp, 16.36.8.13 NMAC 12/27/2022]

HISTORY OF 16.36.8 NMAC:
16.36.8 NMAC, Expedited Licensure for Military Service Members and Veterans, filed 2/3/2022 was repealed and replaced with 16.36.8 Expedited Licensure effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
CHIROPRACTIC, BOARD OF

The New Mexico Chiropractic Board reviewed at its 12/09/2022 hearing, to repeal its rule 16.4.4 NMAC, Chiropractic Practitioners - License Without Examination filed 7/10/2019 and replace it with 16.4.4 NMAC Chiropractic Practitioners - Expedited Licensure, License Without Examination, adopted 12/9/2022 and effective 12/27/2022.

The New Mexico Chiropractic Board reviewed at its 12/9/2022 hearing, repealed its rule 16.4.23 NMAC - Licensure for Military Service Members, Spouses and Veterans filed (3/10/2022). The rule repeal was adopted 12/9/2022 and is effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
CHIROPRACTIC, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 4 CHIROPRACTIC PRACTITIONERS
PART 4 EXPEDITED LICENSURE, LICENSE WITHOUT EXAMINATION

16.4.4.1 ISSUING AGENCY: New Mexico Chiropractic Board.
[16.4.4.1 NMAC - Rp, 16.4.4.1 NMAC, 12/27/2022]

16.4.4.2 SCOPE: The provisions in Part 4 of Chapter 4 apply to applicants for expedited licensure, also referred to as license without examination.
[16.4.4.1 NMAC - Rp, 16.4.4.1 NMAC, 12/27/2022]

16.4.4.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to and in accordance with the Chiropractic Physician Practice Act, Section 61-4-8 NMSA 1978 and the Uniform Licensing Act, Section 61-1-31.1 NMSA 1978.
[16.4.4.3 NMAC - Rp, 16.4.4.3 NMAC, 12/27/2022]

16.4.4.4 DURATION: Permanent.
[16.4.4.4 NMAC - Rp, 16.4.4.4 NMAC, 12/27/2022]

16.4.4.5 EFFECTIVE DATE: December 27, 2022, unless a later date is cited at the end of a section.
[16.4.4.5 NMAC - Rp, 16.4.4.5 NMAC, 12/27/2022]

16.4.4.6 OBJECTIVES: To promote, preserve and protect the public health, safety and welfare by regulating and setting professional standards for applicants for expedited licensure.
[16.4.4.6 NMAC - Rp, 16.4.4.6 NMAC, 12/27/2022]

16.4.4.7 DEFINITIONS:

A. "Eligible jurisdiction" means:

(1) any state or territory of the United States except those included in the list of disapproved licensing jurisdictions in 16.4.4.8 NMAC; and

(2) any foreign country included in 16.4.4.8 NMAC.

B. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board pursuant to Section 61-4-8 NMSA 1978, and also referred to in the act as a license without examination.

C. "Good standing" means a license or registration is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

D. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-2 NMSA 1978.

E. "Licensing fee" has the same meaning as defined in Paragraph (1) of Subsection E of Section 61-1-34 NMSA 1978.

F. "Military service member" has the same meaning as defined in Paragraph (2) of Subsection E of Section 61-1-34 NMSA 1978.

G. "Veteran" has the same meaning as defined in Paragraph (3) of Subsection E of Section 61-1-34 NMSA 1978.
[16.4.4.7 NMAC - Rp, 16.4.4.7 NMAC, 12/27/2022]

16.4.4.8 LIST OF DISAPPROVED LICENSING JURISDICTIONS; REASONS: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Section 61-4-8 NMSA 1978 of the Chiropractic Physician Practice Act:

A. American Samoa and the Northern Mariana Islands, on the grounds that education and licensure examination requirements cannot be determined to be consistent with those requirements in New Mexico.

B. New York, on the grounds that New York's licensure examination requirements are not consistent with the licensing requirements in New Mexico.

[16.4.4.8 NMAC - Rp, 16.4.4.8 NMAC, 12/27/2022]

16.4.4.9 EXPEDITED LICENSURE APPLICATION:

A. The board shall issue an expedited license to a chiropractic physician who:

(1) is a graduate of a standard college of chiropractic;

(2) holds a valid and unrestricted license, in good standing, in an eligible jurisdiction;

(3) has been a licensed chiropractor for at least two years immediately prior to application in New Mexico.

B. In accordance with Section 61-1-31.1 NMSA 1978, a candidate for expedited licensure must submit to the board a complete application containing the following:

(1) a completed and signed application form;

(2) proof of a current license in good standing from an eligible jurisdiction as defined in these rules;

(3) payment of the required application and license fee pursuant to 16.4.22 NMAC.

C. An expedited license application shall not be deemed complete until the applicant has submitted, and board staff is in receipt of, all of the materials required by Subsection B, including documentation from third parties.

D. Upon receipt of a complete application, board staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

E. If the applicant has a potentially disqualifying criminal conviction, or the board may have other cause to deny the application pursuant to Section 61-4-10 NMSA 1978:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

[16.4.4.9 NMAC - N, 12/27/2022]

16.4.4.10 EXPEDITED LICENSURE APPLICATION FOR MILITARY SERVICE MEMBERS AND VETERANS:

A. A candidate for expedited licensure under Section 61-1-34 NMSA 1978 must submit to the board a complete application containing the following:

(1) a completed and signed application form;

(2) proof of a current license in good standing from another jurisdiction, including a branch of the Unite States armed forces; and

(3) submission of the following documentation:

(a) for military service member: a copy of military orders;

(b) for spouse of military service members: copies of military service member's military orders, and marriage license;

(c) for spouses of deceased military service members: copies of decedent's DD 214 and marriage license;

(d) for dependent children of military service members: copies of military service member's orders listing dependent child or a copy of military orders, and one of the following: a copy of birth certificate, military service member's federal tax return, or other governmental or judicial documentation establishing dependency; or

(e) for veterans (retired or separated): proof of honorable discharge, such as a copy of DD Form 214, DD Form 215, DD form 256, DD Form, 257, NGB Form 22, military ID card, a driver's license or state ID card with a veteran's designation, or other documentation verifying honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and board staff is in receipt of, all of the materials required by subsection A, including documentation from third parties.

C. Upon receipt of a complete application, board staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-4-10 NMSA 1978:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged any initial licensing fees or renewal fees for the first three years of licensure with the board.

[16.4.4.10 NMAC - N, 12/27/2022]

16.4.4.11 EXPEDITED LICENSE DURATION AND RENEWAL:

A. An expedited license, including an expedited licensure issued to a military member under 16.4.4.10 NMAC, shall be valid for the same length of time as a regular license issued by the board and must be renewed on or before July 1 of each year, as provided by 16.4.9.8 NMAC.

B. A licensee holding an expedited license may apply for license renewal in the manner provided by the board's rules. However, if the licensee has not passed the following examinations in another jurisdiction that are required for licensure in New Mexico pursuant to 16.4.6.8 NMAC, the licensee must pass the exam prior to applying for renewal:

(1) the board's jurisprudence exam;

(2) the national board exams I, II, III, and IV; and

(3) the physiotherapy exam conducted by the national board of chiropractic examiners.

C. Upon renewal, the board shall issue a regular license to a licensee holding an expedited license issued pursuant to these rules.

[16.4.4.11 NMAC - N, 12/27/2022]

HISTORY OF 16.4.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:
Rule 17-95, Licensure By Endorsement, filed 2/20/1995.

History of Repealed Material:
16.4.4 NMAC, Licensure Without Examination filed 12/15/2004, Repealed effective 8/10/2019.
16.4.4 NMAC, Licensure Without Examination filed 7/10/2019, Repealed effective 12/27/2022.

Other History:
Rule 17-95, Licensure By Endorsement (filed 2/20/1995) was renumbered, reformatted and replaced by 16 NMAC 4.4, Licensure By Endorsement, effective 11/16/1997.
16 NMAC 4.4, Licensure By Endorsement (filed 10/17/1997) was renumbered, reformatted, amended and replaced by 16.4.4 NMAC, Licensure By Endorsement, effective 1/15/2005.
16.4.4 NMAC, Licensure Without Examination filed 12/15/2004 was replaced by 16.4.4 NMAC, Licensure Without Examination, effective 8/10/2019.
16.4.4 NMAC, Licensure Without Examination filed 7/10/2019 was replaced by 16.4.4 NMAC, Licensure Without Examination, effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
CHIROPRACTIC, BOARD OF

This is an amendment to 16.4.22 NMAC, Section 8, effective 12/27/2022.

16.4.22.8 ADMINISTRATIVE FEES:

A. In accordance with Subsection F of Section 61-4-7 and Subsection B of Section 61-4-13 NMSA 1978 of the New Mexico Chiropractic Physicians Practice Act, the board of chiropractic examiners establishes the following nonrefundable fees:

(1) Initial application for licensure/certification:

(a) application fee $350;

(b) expedited license application fee $200;

(~~b~~) (c) initial license fee [~~with or without examination~~] $350;

(~~c~~) (d) advanced practice certification application fee $100.

(2) Reinstatement and reactivation:

(a) reinstatement of license $125 (in addition to back renewal and penalty fees for each year, not to exceed two years);

(b) reactivation application fee $200.

(3) Annual renewal fees:

(a) active $300;

(b) inactive $100;

(c) advanced practice certification $100;

(d) impairment fee of $25 in addition to the license renewal fee, each chiropractor subject to renewal will be assessed an amount not to exceed $60 per renewal period;

(e) penalty for late renewal $100 (per month or portion of a month for which the license renewal fee is in arrears, the penalty not to exceed $1000).

(4) Continuing education seminars and programs:

(a) continuing education fee individual course $50;

(b) continuing education seminars and programs provided by entities or organizations that meet the criteria established by the board under Subsections E and F of 16.4.10.8 NMAC and who intend to submit approval for more than 10 but less than 25 continuing education programs or seminars will be assessed a fee of $500.

(5) Any requests for approval that exceed 25 continuing education programs or seminars will be assessed a fee of:

(a) $50/program or seminar or;

(b) a fee of $500 if approval is for more than 10 but less than 25 continuing education programs or seminars.

(6) Miscellaneous fees listed below will be approved annually by the board and made available by the board office upon request:

(a) photocopying $0.25;

(b) written license verifications $25;

(c) list of licensees $75;

(d) duplicate licenses $25;

(e) duplicate renewal certificate $25;

(f) copies of statutes, rules and regulations are free online at board web site.

B. The board shall annually designate that proportion of renewal fees which shall be used for the exclusive purposes of investigating and funding hearings regarding complaints against chiropractic physicians.

[16.4.22.8 NMAC - Rp 16.4.22.8 NMAC, 8/10/2019, A, 4/9/2022, A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
DENTAL HEALTH CARE, BOARD OF

The New Mexico Board of Dental Health Care reviewed at its 12/9/2022 hearing, to repeal its rule 16.5.5 NMAC, Dentistry (Dentists, Dental Hygienists. Etc., - Dentists, Fees (filed 6/1/2001) and replace it with 16.5.5 NMAC, Dentistry (Dentists, Dental Hygienists. Etc.), - Dentists, Fees, adopted 12/9/2022 and effective 12/27/2022.

The New Mexico Board of Dental Health Care reviewed at its 12/9/2022 hearing, to repeal its rule 16.5.18 NMAC, Dentistry (Dentists, Dental Hygienists. Etc., - Dental Hygienists, Fees (filed 6/1/2001) and replace it with 16.5.18 NMAC, Dentistry (Dentists, Dental Hygienists. Etc.), - Dental Hygienists, Fees, adopted 12/9/2022 and effective 12/27/2022.

The New Mexico Board of Dental Health Care reviewed at its 12/9/2022 hearing, to repeal its rule 16.5.59 NMAC, Dentistry (Dentists, Dental Hygienists. Etc., - Licensure for Military Service Members, Spouses and Veterans (filed 11/5/2021) and replace it with 16.5.59 NMAC, Dentistry (Dentists, Dental Hygienists. Etc.), - Expedited Licensure And Expedited Licensure For Military Service Members, Spouses, Dependent Children And Veterans, adopted 12/9/2022 and effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
DENTAL HEALTH CARE, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 5 DENTISTRY (DENTISTS, DENTAL HYGIENISTS, ETC.)
PART 5 DENTISTS, FEES

16.5.5.1 ISSUING AGENCY: New Mexico Board of Dental Health Care.
[16.5.5.1 NMAC - Rp, 16.5.5.1 NMAC, 12/27/2022]

16.5.5.2 SCOPE: The provisions of 16.5.5 NMAC apply to all applicants for licensure; to active, expedited, retired, expired and suspended licensees; and to anyone who requests a list or labels of licensed dentists, multiple copies of the law or rules, or copies of public records.
[16.5.5.2 NMAC - Rp, 16.5.5.2 NMAC, 12/27/2022]

16.5.5.3 STATUTORY AUTHORITY: 16.5.5 NMAC is promulgated pursuant to the Dental Health Care Act, Section 61-5A-20 NMSA 1978 (1996 Repl. Pamp.).
[16.5.5.3 NMAC - Rp, 16.5.5.3 NMAC, 12/27/2022]

16.5.5.4 DURATION: Permanent.
[16.5.5.4 NMAC - Rp, 16.5.5.4 NMAC, 12/27/2022]

16.5.5.5 EFFECTIVE DATE: December 27, 2022, unless a later date is cited at the end of a section.
[16.5.5.5 NMAC - Rp, 16.5.5.5 NMAC, 12/27/2022]

16.5.5.6 OBJECTIVE: To establish fees to generate revenue adequate to fund the cost of program administration.
[16.5.5.6 NMAC - Rp, 16.5.5.6 NMAC, 12/27/2022]

16.5.5.7 DEFINITIONS: [RESERVED]
[16.5.5.7 NMAC - Rp, 16.5.5.7 NMAC, 12/27/2022]

16.5.5.8 FEES:

A. All fees are non-refundable.

B. Application for licensure by examination fee is $600, which includes the initial licensing period.

C. Application for licensure by credential fee is $850, which includes the initial licensing period.

D. An applicant who does not obtain a passing score on the jurisprudence exam must submit an additional fee of $100 to re-take the exam.

E. Triennial renewal fee for all dental licensees is $550.

(1) Impaired fee is $30 per triennial renewal period plus renewal fee.

(2) Late renewal fee of $100 after July 1 through September 1 plus renewal and impaired fees.

(3) Cumulative late fee of $10 per day from August 1 to the date of the postmark or hand-delivery to the board office plus renewal, late and impaired fees.

F. Triennial renewal fee for inactive license is $90.

G. Temporary license fees:

(1) 48- hour license, application fee of $50, license fee of $50;

(2) six- month license, application fee of $100, license fee of $200;

(3) 12- month license, application fee of $100, license fee of $300;

(4) 12 month license for student enrolled in residency program, application fee of $25.00, license fee of $50.00.

H. Anesthesia permit fees:

(1) nitrous oxide permit fee is $25;

(2) minimal sedation permit fee is $25;

(3) moderate sedation permit fee is $300;

(4) deep sedation and general anesthesia permit fee is $300.

I. Reinstatement fee is $400.

J. Application for licensure for inactive status is $50.

K. Non-dentist owner fees.

(1) Application for licensure fee is $300, which includes the initial licensing period.

(2) Triennial renewal fee of $150.

(3) Late renewal fee of $100 after July 1 through September 1 plus renewal fee.

(4) Cumulative late fee of $10 per day from August 1 to the date of the postmark or hand-delivery to the board office plus renewal and late fee.

L. Administrative and duplication fees:

(1) duplicate license fee is $25;

(2) multiple copies of the statute or rules are $10 each;

(3) copy fees are $0.25 per page;

(4) list of current dental licensees is $300; an annual list of current licensees is available to the professional association upon request at no cost; and

(5) mailing labels of current dental licensees is $300.

M. Expedited licensure fees. The fees for expedited licensure submitted pursuant to Subsection B of Section 61-5A-14 NMSA 1978 are a $100 application fee and a $300 license fee.

[16.5.5.8 NMAC - Rp, 16.5.5.8 NMAC, 12/27/2022]

HISTORY of 16.5.5 NMAC:
Pre-NMAC History:
Material in this part was derived from that previously filed with the commission of public records - state records center and archives as:
Article IV, Licensing of Dentist, filed 03/11/1981;
Article IV, Licensing of Dentist, filed 01/12/1982;
Article IV, Licensing of Dentist, filed 03/30/1982;
BOD Rule 4, Licensing of Dentists, filed 02/09/1989;
BODHC Rule DS 6-95, Dentistry, Fees, filed 05/05/1995.

History of Repealed Material:
16.5.5 NMAC, Dentists, Fees, filed 6/1/2001 Repealed 12/27/2022.

Other History:
16 NMAC 5.5, Dentists, Fees, filed 09/17/1996;
16 NMAC 5.5, Dentists, Fees, filed 09/17/1996 - renumbered, reformatted and amended to 16.5.5 NMAC, Dentists, Fees, effective 06/14/2001.
16.5.5 NMAC, Dentists, Fees, filed 6/1/2001 Replaced by 16.5.5 NMAC, Dentists, Fees, effective 12/27/2022

REGULATION AND LICENSING DEPARTMENT
DENTAL HEALTH CARE, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 5 DENTISTRY (DENTISTS, DENTAL HYGIENISTS, ETC.)
PART 18 DENTAL HYGIENISTS, FEES

16.5.18.1 ISSUING AGENCY: New Mexico Board of Dental Health Care.
[16.5.18.1 NMAC - Rp, 16.5.18.1 NMAC, 12/27/2022]

16.5.18.2 SCOPE: The provisions of 16.5.18 NMAC apply to all applicants for licensure; to active, expedited, retired, expired and suspended licenses; to anyone who requests a list or labels of licensed dental hygienists, multiple copies of the law or rules, or copies of public records.
[16.5.18.2 NMAC - Rp, 16.5.18.2 NMAC, 12/27/2022]

16.5.18.3 STATUTORY AUTHORITY: 16.5.18 NMAC is promulgated pursuant to the Dental Health Care Act, Section 61-5A-14 NMSA 1978 (1996 Repl. Pamp.).
[16.5.18.3 NMAC - Rp, 16.5.18.3 NMAC, 12/27/2022]

16.5.18.4 DURATION: Permanent.
[16.5.18.4 NMAC - Rp, 16.5.18.4 NMAC, 12/27/2022]

16.5.18.5 EFFECTIVE DATE: December 27, 2022, unless a later date is cited at the end of a section.
[16.5.18.5 NMAC - Rp, 16.5.18.5 NMAC, 12/27/2022]

16.5.18.6 OBJECTIVE: To establish fees to generate revenue to support the cost of program administration.
[16.5.18.6 NMAC - Rp, 16.5.18.6 NMAC, 12/27/2022]

16.5.18.7 DEFINITIONS: [**RESERVED**]
[16.5.18.7 NMAC - Rp, 16.5.18.7 NMAC, 12/27/2022]

16.5.18.8 FEES:

A. All fees are non-refundable.

B. Application fee for licensure by examination is $350, which includes the initial licensing period.

C. Application fee for licensure by credentials is $400, which includes the initial licensing period.

D. An applicant who does not obtain a passing score on the jurisprudence exam must submit an additional fee of $50 to re-take the exam.

E. Triennial renewal fee for all dental hygienist licensee is $325:

(1) impaired fee is $15 per triennial renewal period plus renewal fee;

(2) late renewal fee of $100 after July 1 through September 1, plus renewal and impaired fees;

(3) cumulative late fee of $5 per day from August 1 to the date of the postmark or hand-delivery to the board office plus renewal, late and impaired fees.

F. Fees for collaborative practice:

(1) application for certification for collaborative practice fee is $150;

(2) renewal of certification for collaborative practice fee is $50 at the time of each triennial license renewal; the initial fee will be prorated at $20 per full year of certification.

G. Fees for temporary licenses and application:

(1) 48 hour license, application fee of $50, license fee of $50;

(2) six month license, application fee of $100, license fee of $100;

(3) 12 month license, application fee of $100, license fee of $150.

H. Application for certification in local anesthesia fee:

(1) by examination - $40;

(2) by credentials - $100 for application and credential review.

I. Reinstatement fee is $200.

J. Application for licensure for inactive status is $50.

K. Administrative fees:

(1) duplicate license fee is $25;

(2) multiple copies of the statute or rules are $10 each;

(3) copies cost $0.25 per page;

(4) list of current dental hygiene licensees is $300; an annual list of current licensees is available to the professional association upon request at no cost; and

(5) mailing labels of current dental hygiene licensees is $300.

L. Expedited licensure fees. The fees for expedited licensure submitted pursuant to Subsection B of Section 61-5A-14 NMSA 1978 are a $100 application fee and a $150 license fee.

[16.5.18.8 NMAC - Rp, 16.5.18.8 NMAC, 12/27/2022]

HISTORY OF 16.5.18 NMAC:
Pre/NMAC History:
Material in this part was derived from that previously filed with the commission of public records / state records center and archives as:
Article VIII, Licensing of Dental Hygienists, filed 03/12/1981;
Article VIII, Licensing of Dental Hygienists, filed 01/12/1982;
Article, VIII, Licensing of Dental Hygienists, filed 03/30/1982;
BOD Rule 7, Licensing of Dental Hygienists, filed 02/09/1989;
BODHC Rule DH 6/95, Dental Hygienists, Fees, filed 05/05/1995.

History of Repealed Material:
16.5.18 NMAC, Dental Hygienists, Fees, filed 6/1/2001, Repealed effective 12/27/2022.

Other History:
16 NMAC 5.18, Dental Hygienists, Fees, filed 09/17/1996;
16 NMAC 5.18, Dental Hygienists, Fees, filed 09/17/1996 / renumbered, reformatted and amended to 16.5.18 NMAC, Dental Hygienists, Fees, effective 06/14/2001.
16.5.18 NMAC, Dental Hygienists, Fees, filed 6/1/2001, Replaced by 16.5.18 NMAC, Dental Hygienists, Fees, filed effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
DENTAL HEALTH CARE, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 5 DENTISTRY (DENTISTS, DENTAL HYGIENISTS, ETC.)
PART 59 EXPEDITED LICENSURE AND EXPEDITED LICENSURE FOR MILITARY SERVICE MEMBERS, SPOUSES, DEPENDENT CHILDREN AND VETERANS

16.5.59.1 ISSUING AGENCY: New Mexico Board of Dental Health Care.
[16.5.59.1 NMAC - Rp, 16.5.59.1 NMAC, 12/27/2022]

16.5.59.2 SCOPE: The provisions in Part 59 of Chapter 5 apply to applicants for expedited licensure pursuant to Subsection B of 61-5A-14 NMSA 1978 and Subsection B of 61-1-34 NMSA 1978.
[16.5.59.2 NMAC - Rp, 16.5.59.2 NMAC, 12/27/2022]

16.5.59.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to Section 61-1-34 of the Uniform Licensing Act, Section 61-1-1 to 34 NMSA1978, (1957, as amended through 2013) and the Dental Health Care Act Sections 61-5A-1 through 61-5A -30 NMSA 1978.
[16.5.59.3 NMAC - Rp, 16.5.59.3 NMAC, 12/27/2022]

16.5.59.4 DURATION: Permanent.
[16.5.59.4 NMAC - Rp, 16.5.59.4 NMAC, 12/27/2022]

16.5.59.5 EFFECTIVE DATE: December 27, 2022 unless

a later date is cited at the end of a section.
[16.5.59.5 NMAC - Rp, 16.5.59.5 NMAC, 12/27/2022]

16.5.59.6 OBJECTIVE: The purpose of this part is to expedite licensure for all applicants pursuant to Subsection B of 61-5A-14 and Section 61-1-34 NMSA 1978.
[16.5.59.6 NMAC - Rp, 16.5.59.6 NMAC, 12/27/2022]

16.5.59.7 DEFINITIONS:

A. "**Eligible jurisdiction"** means:

(1) any state or territory of the United States except those included in the list of disapproved jurisdictions in 16.5.59.8 NMAC; and

(2) any foreign country included in 16.5.59.10. NMAC.

B. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

C. "Good standing" means a license or registration is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

D. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-2, NMSA 1978.

E. "License" means a license, registration certificate of registration, certificate, permit or certification.

F. "Licensing fee" means a fee charged at the time an application for a professional or occupational license is submitted to the state agency, board or commission and any fee charged for the processing of the application for such license; "licensing fee" does not include a fee for an annual inspection or examination of a licensee or a fee charged for copies of documents, replacement license or other expenses related to a professional or occupational license.

G. "Military service member" means a person who is:

(1) serving in the armed forces of the United States as an active duty member, or in an active
reserve component of the armed forces of the Unites States, including the national guard, or a surviving spouse of a member who at the time of the member's death was serving on active duty; or

(2) the spouse of 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, or a surviving spouse of a member who at the time of the member's death was serving on active duty; or

(3) the child of a person who is serving in the armed forces of the United States as an active duty member, or in an active reserve component of the armed forces of the United States, including the national guard; provided that child is also a dependent of that person for federal income tax purposes.

H. "Qualified applicant" means an applicant who:

(1) holds a current license in good standing in another jurisdiction, provided that an applicant who is not a military service member or veteran must hold a current license in good standing in an eligible jurisdiction;

(2) does not have a disqualifying criminal conviction, as defined in the board's rules; and

(3) is not subject to pending disciplinary action in New Mexico or any other licensing jurisdiction.

I. "Veteran" has the same meaning as defined in Paragraph (3) of Subsection E of Section 61-1-34, NMSA 1978.
[16.5.59.7 NMAC - Rp, 16.5.59.7 NMAC, 12/27/2022]

16.5.59.8 EXPEDITED LICENSURE REQUIREMENTS AND APPLICATION:

A. In accordance with Subsection B of Section 61-5A-14 and 61-1-31.1, NMSA 1978, the board may issue an expedited license to a qualified applicant who holds a valid license, in good standing, that was issued in another licensing jurisdiction and submits the following information to the board:

(1) a completed and signed application form;

(2) proof of a current license in good standing in an eligible jurisdiction as defined in these rules; and

(3) payment of the required application fee.

B. Successfully pass a New Mexico jurisprudence exam.

C. An expedited license application shall not be deemed complete until the applicant has submitted, and board staff is in receipt of, all of the materials required by Subsection A and B of 16.5.59.8 NMAC, including documentation by third parties.

D. Upon receipt of a complete application the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

E. If the applicant has a potentially disqualifying criminal conviction or the board has other cause to deny the application pursuant to Section 61-5A-21, NMSA 1978:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at its next available, regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

F. An expedited license issued pursuant to Subsection B of 61-5A-14 and 61-1-31.1, NMSA 1978 is a one-year provisional license that confers the same rights, privileges

and responsibilities as regular licenses issued by the board.

G. Before the end of expedited license period and upon application, the board shall issue a regular license through its renewal process. However, if the licensee's prior licensing jurisdiction did not require examination, the licensee shall be required to pass a board approved clinical examination, as required by 16.5.6.8 NMAC and 16.5.19.8 NMAC, prior to issuing a regular license.

[16.5.59.8 NMAC - Rp, 16.5.59.8 NMAC, 12/27/2022]

16.5.59.9 LIST OF DISAPPROVED LICENSING JURISDICTIONS FOR DENTISTS AND DENTAL HYGIENISTS:

A. Pursuant to Subsection C of Section 61-5A-14 NMSA 1978 of the Dental Health Care Act, applicants for licensure as a dentist licensed in the following state and territories for the United States shall not be eligible for expedited licensure because the education requirements are not or cannot be determined to be, consistent with New Mexico:

(1) American Samoa;

(2) Puerto Rico; and;

(3) Washington.

B. Pursuant to Subsection C of Section 61-5A-14 NMSA 1978 of the Dental Health Care Act, applicants for licensure as a dental hygienist licensed in the following states and territories of the United States shall not be eligible for expedited licensure because the education requirements are not, or cannot be determined to be. consistent with New Mexico:

(1) American Samoa;

(2) Alabama;

(3) Arizona;

(4) Delaware;

(5) Florida;

(6) Mississippi;

(7) New York;

(8) Northern Mariana Islands;

(9) Oregon;

(10) Puerto Rico; and

(11) Guam.

[16.5.59.9 NMAC - N, 12/27/2022]

16.5.59.10 LIST OF APPROVED FOREIGN JURISDICTIONS: The board has not recognized any foreign jurisdictions from which it will accept an applicant for expedited licensure. However, the board will conduct a periodic review to determine if any amendments to this rule are warranted.

[16.5.59.10 NMAC - Rp, 16.5.59.10 NMAC, 12/27/2022]

16.5.59.11 EXPEDITED LICENSURE APPLICATION FOR MILITARY SERVICE MEMBERS AND VETERANS:

A. An applicant for expedited licensure under Section 61-1-34, NMSA 1978 shall submit to the board a complete application containing the following:

(1) a completed and signed application form;

(2) proof of a current license in good standing in another jurisdiction, including a branch of the United States armed forces; and

(3) submission of the following documentation:

(a) for military service member: a copy of military orders;

(b) for spouse of military service members: copy of military service member's military orders, and copy of marriage license;

(c) for spouses of deceased military service members: copy of decedent's DD 214 and copy of marriage license;

(d) for dependent children of military service members: a copy of military service member's orders listing dependent child, or a copy of military orders and one of the following: a copy of birth certificate, military service member's federal tax return or other governmental or judicial documentation establishing dependency; or

(e) for veterans (retired or separated): proof of honorable discharge such as a copy of DD Form 214, DD Form 215, DD Form 256, DD Form 257, NGB Form 22, military ID card, a driver's license or state ID card with a veteran's designation, or other documentation verifying honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-5A-21 NMSA 1978:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged a licensing fee for the first three years of licensure with the board.

F. An expedited license issued to a military service member or veteran pursuant to Section 61-1-34, NMSA 1978, shall be valid for the same length of time as

a regular initial license issued by the board.

G. A license issued pursuant to this section shall not be renewed unless the license holder satisfies the examination requirements set forth in 16.5.6 NMAC, 16.5.19 NMAC, 16.5.33 NMAC, 16.5.42 NMAC, 16.5.50 NMAC, and 16.5.61 NMAC.

[16.5.59.11 NMAC - N, 12/27/2022]

HISTORY OF 16.5.59 NMAC: [RESERVED]

History of Repealed Material:
16.5.59 NMAC, Dentistry (Dentists, Dental Hygienists, Etc.) - Licensure for Military Service Members, Spouses and Veterans filed 12/5/2013, Repealed effective 12/5/2021.
16.5.59 NMAC, Dentistry (Dentists, Dental Hygienists, Etc.) - Licensure for Military Service Members, Spouses and Veterans filed 11/5/2021, Repealed effective 12/27/2022.

Other History: 16.5.59 NMAC, Dentistry (Dentists, Dental Hygienists, Etc.) - Licensure for Military Service Members, Spouses and Veterans filed 12/5/2013, was replaced by 16.5.59 NMAC, Dentistry (Dentists, Dental Hygienists, Etc.) - Licensure for Military Service Members, Spouses and Veterans effective 12/5/2021.
16.5.59 NMAC, Dentistry (Dentists, Dental Hygienists, Etc.) - Licensure for Military Service Members, Spouses and Veterans filed 11/5/2021, was replaced by 16.5.59 NMAC, Dentistry (Dentists, Dental Hygienists, Etc.) - Expedited Licensure And Expedited Licensure For Military Service Members, Spouses, Dependent Children And Veterans, effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
LANDSCAPE AND ARCHITECTS, BOARD OF

This is an amendment to 16.44.2 NMAC, Sections 1 and 11 effective 12/27/2022.

16.44.2.1 ISSUING AGENCY: New Mexico Board of Landscape Architects [~~P.O. Box 25101, Santa Fe, NM 87504~~].
[16.44.2.1 NMAC - Rp, 16.44.2.1 NMAC, 9/30/2016; A, 12/27/2022]

16.44.2.11 [~~RECIPROCITY:~~ ~~The board may issue a license to practice as a registered landscape architect without an examination to an applicant who holds a current registration or license as a landscape architect issued by another state if the standards of the other state are as stringent or higher than those established by the rules and regulations and if the applicant meets the qualifications required of a registered landscape architect in this state.~~] [**RESERVED**]
[16.44.2.11 NMAC - Repealed, 16.44.2.11 NMAC, 9/30/2016; 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
LANDSCAPE AND ARCHITECTS, BOARD OF

This is an amendment to 16.44.3 NMAC, Sections 1, 12, 13, 18 effective 12/27/2022.

16.44.3.1 ISSUING AGENCY: New Mexico Board of Landscape Architects [~~P.O. Box 25101, Santa Fe, NM 87504~~].
[16.44.3.1 NMAC - Rp, 16.44.3.1 NMAC, 9/30/2016; A, 12/27/2022]

16.44.3.12 [~~LANDSCAPE ARCHITECT APPLICANTS LICENSED IN ANOTHER JURISDICTION, AND WHO ARE NOT CLARB CERTIFIED:~~

~~**A.** The board may issue a license to practice as a landscape architect without an examination to an applicant who holds a current registration or license as a landscape architect issued by another jurisdiction if the education and experience requirements of the other jurisdiction are as stringent or higher than those established in the board's rules and regulations and if the applicant meets the qualifications required of a registered landscape architect in this state.~~

~~**B.** Application procedure: To open an application file, the applicant shall submit the following:~~

~~**(1)** a completed and signed application;~~

~~**(2)** the application fee as required by the board;~~

~~**(3)** official educational transcripts sent to the board office directly from the institution's office of the registrar;~~

~~**(4)** verification of practical experience;~~

~~**(5)** samples of work; practical experience for licensure for an applicant shall begin after graduation from the school, college or university program as described in 16.44.2 NMAC; to assist the board in evaluating the applicants practical experience, the applicant shall submit evidence of his or her experience with the completed application form in in one or both of the following formats:~~

~~**(a)** a minimum of six and a maximum of 10 graphic images (formatted to 8 ½ "x 11") of projects or drawings depicting construction, planting, irrigation, or design; or~~

~~**(b)** a maximum two-page summary or abstract that describes relevant experience such as administration, research, planning, or teaching.~~

~~**(6)** letters of reference: An applicant for licensure as a landscape architect shall submit three letters of reference, two of which shall be from individuals who are not members of the board; the letters of reference shall be from individuals who are not related to the applicant and who are familiar with and will speak to the applicant's professional activities as a landscape architect;~~

~~**(7)** verification of licensure in another jurisdiction; and~~

~~**(8)** documentation of the licensing~~

jurisdiction's minimum qualifications for licensure at the time of licensing (i.e. a copy of the applicable law(s) from the licensing jurisdiction at the time of licensure).

C. The board administrator will notify the applicant once the application file appears to be complete. The board will review the application at the next regularly scheduled board meeting. The board administrator will notify the applicant of the board's decision relative to the application.] **[RESERVED]**

[16.44.3.12 NMAC - Repealed, 16.44.3.12 NMAC, 9/30/2016; A, 12/27/2022]

16.44.3.13 [LANDSCAPE ARCHITECT APPLICANTS WHO ARE CLARB CERTIFIED:

A. Initial application procedure. To open an initial application file, the applicant shall submit the following:

(1) a completed and signed application;

(2) the application fee as required by the board;

(3) certification received directly from CLARB.

B. Once the application file is complete the board office will notify the applicant. The board administrator has been authorized by the board to then issue a license to the applicant.] **[RESERVED]**

[16.44.3.13 NMAC - Repealed, 16.44.3.13 NMAC, 9/30/2016; A, 12/27/2022]

16.44.3.18 [EXPEDITED LICENSURE/CERTIFICATION BY RECIPROCITY FOR MILITARY AND SPOUSES LICENSED IN ANOTHER JURISDICTION:

A. If a military service member, the spouse of a military service member, or a recent veteran submits an application for license or certification and is a qualified applicant pursuant to this part, the board shall expedite the processing of such application and issue the license or certification as soon as practicable. The terms "military service member" and "recent veteran" are defined in the Uniform Licensing Act, 61-1-34 NMSA 1978. Any qualified veteran applicant seeking expedited licensure pursuant to this section shall submit a copy of form DD214, certificate of release or discharge from active duty, with the application.

B. A license or certification issued pursuant to this section shall not be renewed automatically, and shall be renewed only if the licensee or certificate holder satisfies all requirements for the issuance and renewal of a license or certificate pursuant to the Landscape Architects Act and the board's rules, including 16.44.4 NMAC.] **[RESERVED]**

[16.44.3.18 NMAC - N, 9/30/2016; Repealed, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
LANDSCAPE AND ARCHITECTS, BOARD OF

This is an amendment to 16.44.4 NMAC, Sections 1 and 8 effective 12/27/2022

16.44.4.1 ISSUING AGENCY: New Mexico Board of Landscape Architects [P. O. Box 25101, Santa Fe, NM 87504].

[16.44.4.1 NMAC - Rp, 16 44.4.1 NMAC, 9/30/2016; A, 12/27/2022]

16.44.4.8 LICENSE AND CERTIFICATE RENEWAL:

A. Each landscape architect shall renew his or her license to practice landscape architecture in New Mexico annually on or before June 30 of the year by remitting to the board administrator a renewal fee with the renewal application form provided by the board. Continuing education hours shall be documented as described in 16.44.5.8. NMAC.

B. Each landscape architect in training shall renew his or her certificate to practice in New Mexico annually on or before June 30 of the year by remitting to the board administrator a renewal fee with the renewal application form provided by the board.

[**C.** As provided by 16.44.3.18 NMAC, a license or certificate issued pursuant to the expedited licensure of a military service member or a spouse of a military service member or a recent veteran shall not be renewed unless the licensee or certificate holder satisfies the requirements for the issuance and for the renewal of a license pursuant to the Landscape Architects Act, 61-24B NMSA 1978 and 16.44.3.8 through 16.44.3.13 NMAC and 16.44.4.8 through 16.44.4.13 NMAC.]

[16.44.4.8 NMAC - Rp, 16 44.4.8 NMAC, 9/30/2016; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
NURSING HOME ADMINISTRATORS, BOARD OF

The Board of Nursing Home Administrators, after a rule hearing conducted on December 9, 2022, has approved a repeal of its rule 16.13.5 Application for Licensure by Reciprocity NMAC-, (filed 02/26/2022) was repealed and replaced by 16.13.5 -Expedited Licensure, effective 01/14/2023. The rule repeal was adopted on December 9, 2022, and is effective January 14, 2023.

The Board of Nursing Home Administrators, after a rule hearing conducted on December 9, 2022, has approved a repeal of its rule 16.13.6 Licensure for Military Service Members, Spouses, Dependent Children and Veterans NMAC-, (filed 02/26/2022) effective 1/14/2023. The rule repeal was adopted on December 20, 2022, and is effective January 14, 2023.

REGULATION AND LICENSING DEPARTMENT
NURSING HOME ADMINISTRATORS, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 13 NURSING HOME ADMINISTRATORS
PART 5 EXPEDITED LICENSURE

16.13.5.1 ISSUING AGENCY: New Mexico Nursing Home Administrators Board.
[16.13.5.1 NMAC – Rp, 16.13.5.1 NMAC, 1/14/2023]

16.13.5.2 SCOPE: The provisions in Part 5 of Chapter 13 apply to all persons applying to the board for nursing home administrator licensure by reciprocity.
[16.13.5.2 NMAC – Rp, 16.13.5.2 NMAC, 1/14/2023]

16.13.5.3 STATUTORY AUTHORITY: Part 5 of Chapter 13 is promulgated pursuant to the Nursing Home Administrators Act, Sections 61-13-6, 61-13-8, 61-13-11, 61-13-12 and 61-13-13 NMSA1978. (1997 Repl. Pamp.).
[16.13.5.3 NMAC – Rp, 16.13.5.3 NMAC, 1/14/2023]

16.13.5.4 DURATION: Permanent.
[16.13.5.4 NMAC – Rp, 16.13.5.4 NMAC, 1/14/2023]

16.13.5.5 EFFECTIVE DATE: January 14, 2023, unless a later date is cited at the end of a section.
[16.13.5.5 NMAC – Rp, 16.13.5.5 NMAC, 1/14/2023]

16.13.5.6 OBJECTIVE: The objective of Part 5 of Chapter 13 is to establish the requirements applicants for licensure by reciprocity must meet in order to be qualified and licensed by the board to practice nursing home administration in New Mexico.
[16.13.5.6 NMAC, Rp, 16.13.5.6 NMAC, 1/14/2023]

16.13.5.7 DEFINITIONS: [RESERVED]

A. "Eligible jurisdiction" means any state or territory of the United States except those included in the list of disapproval licensing jurisdictions in 16.16.4.8 NMAC.

B. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

C. "Good Standing" means a license is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

D. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-2 NMSA 1978.

E. "Licensing fee" has the same meaning as defined in Paragraph (1) of Subsection E of Section 61-1-34 NMSA 1978.

F. "Military service member" has the same meaning as defined in Paragraph (2) of Subsection E of Section 61-1-34 NMSA 1978.

G. "Qualified application" means an applicant who:

(1) holds a current license in good standing in another jurisdiction, as defined by Subsection D of this rule;

(2) does not have a disqualifying criminal conviction, as defined in Subsection A or 16.13.18.8 NMAC of the board's rules; and

(3) is not subject to pending disciplinary action in New Mexico.

H. "Veteran" has the same meaning as defined in Paragraph (3) of Subsection E of Section 61-1-34 NMSA 1978.
[16.13.5.7 NMAC – Rp, 16.13.5.7 NMAC, 1/14/2023

16.13.5.8 LIST OF DISAPPROVED LICENSING JURISDICTIONS:

A. The following jurisdiction on the grounds that the profession does not appear to be licensed or otherwise regulated, and education and examination requirements, if any, cannot be determined:

(1) American Samoa

(2) Northern Mariana Islands;

(3) Puerto Rico;

(4) U.S Virgin Islands**.**

B. Unless the applicant holds a baccalaureate degree from an accredited institution approved by the board as preparation for nursing home administration, the following jurisdictions on that grounds that the education requirements cannot be determined to be consistent with New Mexico's requirements:

(1) Alabama**;**
(2) Arkansas;
(3) Colorado;
(4) Delaware;
(5) District of Columbia**;**
(6) Georgia;
(7) Idaho;
(8) Illinois;
(9) Indiana;
(10) Maryland;
(11) Michigan;
(12) Mississippi;
(13) Missouri**;**
(14) Montana;
(15) Nebraska;
(16) Nevada;
(17) New Jersey;
(18) North Carolina;
(19) North Dakota;
(20) Ohio;
(21) Oklahoma;
(22) Oregon;
(23) Pennsylvania;
(24) South Carolina;

(25) South Dakota;
(26) Tennessee;
(27) Utah;
(28) Vermont;
(29) Virginia;
(30) Washington;
(31) West Virginia;
(32) Wisconsin;
(33) Wyoming;
(34) Guam.

[16.13.5.8 NMAC – Rp, 16.13.5.8 NMAC, 1/14/2023]

16.13.5.9 [**RESERVED**]

[16.13.5.9 NMAC – Rp, 16.13.5.9 NMAC, 01/14/2023]

16.13.5.10 EXPEDITED LICENSURE APPLICATION:

A. A candidate for expedited licensure under Section 61-1-31.1 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application

(2) Proof of current unrestricted licensure in good standing held by the applicant in an eligible jurisdiction(s).

(3) Certificate of good standing for the licensure held by the applicant in an eligible jurisdiction;

(4) Payment of the required application fee.

B. An expedited license application shall not be deemed complete until the applicant has submitted, the board is in receipt of all of the materials required nu subsection A, including documents from third parties.

C. Upon receipt of complete application the board's staff shall process the application and issue the expedited license to qualified application within 30 days.

D. If the applicant has disqualifying criminal conviction or the board may have other cause to deny the applicant pursuant to Section 61-13-13 NMSA 1978.

(1) The matter of the applicant's application shall be submitted to the board office for consideration and action at its next available regular meeting;

(2) The license may not be issued within 30 days submission of the complete application ; and

(3) The board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

[16.13.5.10 NMAC – Rp, 16.13.5.10 NMAC, 01/14/2023]

16.13.5.11 EXPEDITED LICENSURE FOR MILITARY SERVICE AND VETERANS:

A. A candidate for expedited licensure under Section 61-1-34 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application form;

(2) Proof of current license in good standing in another jurisdiction, including a branch of the United States armed forces; and

(3) Submission of the following documentation:

(a) for military service member: a copy of military orders;

(b) for spouse of military service members: copy of military service member's military orders, and copy of marriage license;

(c) for spouses deceased military service members: copy of decedent's DD214 and copy of marriage license;

(d) for dependent children of military service members: a copy of military service member's orders listing dependent child, or copy of military orders and one of the following: a copy of birth certificate, military service member's federal tax return or other governmental or judicial documentation establishing dependency; or

(e) for veterans (retired or separated), proof of honorable discharge, such as a copy of DD Form 214, DD Form 215, DD Form 256, DD Form 257, NGB Form 22, military ID card, driver's license or state ID card with a veteran's designation, or other documentation verifying honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by Subsection A, including documentation from third partied

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-13-13 NMSA 1978;

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) The license nay not be issued within 30 days of submission of the completed application; and

(3) The board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged any initial licensing fee or renewal fees for the first three years of licensure with the board.

[16.13.5.11 NMAC – Rp, 16.13.5.11 NMAC, 01/14/2023]

16.13.5.12 EXPEDITED LICENSE DURATION AND RENEWAL:

A. An expedited license shall be valid for the same length of time as a regular license issued by the board and must be

renewed on or before March 31 of each year, as provided by 16.13.8 NMAC.

B. A licensee holding an expedited license may apply for license renewal in the manner provided by the board's rules.

C. Upon renewal, the board shall issue a regular license to a licensee holding an expedited license issued pursuant to these rules.
[16.13.5.12 NMAC – Rp, 16.13.5.12 NMAC, 01/14/2023]

HISTORY of 16.13.5 NMAC:
Pre-NMAC History: Material in the part was derived from that previously filed with the commission of public records - state records center and archives:
NHA Manual #88-1, Administrative Rules and Regulations of the New Mexico Board of Nursing Home Administrators, filed 1/25/1988.

History of Repealed Material:
16.13.5 NMAC, Application for Licensure by Reciprocity, filed 1/25/2001, replaced by 16.13.5 NMAC, Expedited Licensure, effective 1/14/2023.

Other History:
16 NMAC 13.5, Application for Licensure by Reciprocity, filed 10/13/1995 replaced that relevant portion of NHA Manual #88-1, filed 1/25/1988.
16 NMAC 13.5, Application for Licensure by Reciprocity, filed 10/13/1995, renumbered and reformatted to 16.13.5 NMAC, Application for Licensure by Reciprocity, effective 1/25/2001.

REGULATION AND LICENSING DEPARTMENT
NURSING HOME ADMINISTRATORS, BOARD OF

This is an amendment to 16.13.1 NMAC, Section 7, Effective 01/14/2023

16.13.1.7 DEFINITIONS:

A. "**AAHSA**" means the American association of homes and services for the aging.

B. "**ACHCA**" means the American college of health care administrators.

C. "**ACHCE**" means the American college of health care executives

D. "**AUPHA**" means the association of university programs in health care administration.

E. **[RESERVED]**

F. "**Administrator**" means the chief executive officer.

G. "**Applicant**" means a person who has applied for a license.

H. "**Approval**" means the review and acceptance of a specific activity.

I. "**Approval body"** means the agency, institution, or organization with the authorization to award continuing education credit.

J. "**Audit**" means an examination and verification of continuing education documents.

K. **[RESERVED]**

L. "**Board**" means the New Mexico nursing home administrators board.

M. "**CE"** means continuing education.

N. **[RESERVED]**

O. "**Continuing Education Unit (CEU)**" means 10 contact hours (60-minute clock hours) of participation in an organized continuing education experience under responsible sponsorship, capable direction, and qualified instruction.

P. "**Contact hours**" means a unit of measurement to describe an approved, organized learning experience. One contact hour equals one 60-minute clock hour.

Q. "**Continuing Education**" means a learning experience which enhances professional development.

R. **[RESERVED]**

S. "**Expired license**" means a license which has not been renewed or placed on inactive status on or before the expiration deadline, as provided in 16.13.10 NMAC.

T. "**Hospital Administrator**" means the chief executive officer of an acute care facility.

U. "**Inactive Status**" means a license which is in good standing but not current, as provided in 16.13.9 NMAC.

V. "**Initial license**" means the process of achieving the legal privilege to practice within a professional category upon the completion of educational and other requirements and receiving a passing score on the national licensing examination.

W. "**Institution of higher learning**" means a college or university.

X. **[RESERVED]**

Y. "**Lapsed license**" means an expired or inactive status license which has not been reactivated within the time limitations set forth in these rules, as provided in 16.13.9 NMAC.

Z. "**License**" means a document identifying the legal privilege and authorization to practice within a professional category.

AA. "**Manager**" means the individual who is responsible for the planning, organizing, directing, and controlling of the operations within a department or unit of a nursing home.

BB. "**Must**" means required.

CC. "**NAB**" means the national association of long-term care administrator boards.

DD. "**NCERS**" means the national continuing education review service.

EE. "**NHA**" means nursing home administrator.

FF. "**NMAC**" means the New Mexico administrative code.

GG. "**New Mexico Administrative Code**" means the organizing structure for rules filed by New Mexico state agencies. The NMAC is also the body of filed rules and the published versions thereof. The NMAC is structured by title, chapter, and part.

HH. "**NMHCA**" means the New Mexico health care association.

II. "**NMHHSA**" means the New Mexico hospitals and health systems association.

JJ. "**NMSA**" means New Mexico statutes annotated.

KK. "National licensing examination" means any examination for licensure as provided by the national association of long-term care administrator boards (NAB).

LL. "**Nursing home administrator**" means any individual responsible for planning, organizing, directing, and controlling the operation of a nursing home.

MM. [RESERVED]

NN. "**PES**" means the professional examination service.

OO. "**Reactivation**" means the process of making current a license which has been expired as a result of failure to comply with the necessary renewal requirements. This process does not usually require board action at any juncture.

PP. ["~~**Reciprocity**" means the process of applying for licensure by providing proof of successful passage of the national licensing exam prior to licensure in another state, and proof of current license in good standing in another state.~~] "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

QQ. "**Reinstatement**" means the process whereby a license, which has been subject to revocation or suspension, is returned to its former status. The reinstatement process always requires board action.

RR. "**Relicensure**" means the process of renewal, reactivation, or reinstatement of a New Mexico nursing home administrator's license.

SS. "**Shall**" means mandatory; a requirement.

TT. "**Should**" means a suggestion or recommendation; not a requirement.

UU. [RESERVED]

[~~**VV. "ULA**" means the Uniform Licensing Act of New Mexico.~~]

[~~**WW. "Uniform Licensing Act**" means Section 61-1-1 to 61-1-33 NMSA 1978 (1993 Repl. Pamp.) which provides for hearing procedures to be utilized in disciplinary proceedings.~~]

[~~**XX.**~~] **VV**.

"**Verification of continuing education**" means an official certificate issued at a continuing education activity which provides proof of attendance.

[~~**YY.**~~] **WW.** "**Violation of practice**" means a violation of the New Mexico Nursing Home Administrators Act and the rules and regulations duly adopted by the board. [2/24/1988; 9/18/1992; 10/31/1995; 16.13.1.7 NMAC - Rn, 16 NMAC 13.1.7, 1/25/2001; A, 2/26/2022, A, 01/14/2023]

REGULATION AND LICENSING DEPARTMENT
NURSING HOME ADMINISTRATORS, BOARD OF

This is an amendment to 16.13.2 NMAC, Sections 6, 8, effective 01/14/2023

16.13.2.6 OBJECTIVE: The objective of Part 2 of Chapter 13 is to establish the fees [~~to generate sufficient revenues required by the Board to carry out its administrative functions.~~] for licenses, and for renewal of licenses, and other related administrative processes. [10/31/1995; 16.13.2.6 NMAC - Rn, 16 NMAC 13.2.6, 1/25/2001; A, 01/14/2023]

16.13.2.8 FEES:

A. All fees are non-refundable.

B. Application and licensure fees for exam candidate:

(1) application fee: $200.00;

(2) licensure fee: $200.00.

C. Examination and computer based testing fees: are payable directly to NAB by electronic means.

D. Reexamination fee [~~The current cost of the national licensing exam and testing center's fees~~] are payable directly to NAB [~~on-line~~] by electronic means.

E. Renewal fee: $200.00.

F. Application and licensure fees for [~~reciprocity candidate~~] expedited licensure applicant:

(1) application fee: $200.00;

(2) licensure fee: $200.00.

G. Late penalty fee: $100.00.

H. Inactive status fee: $75.00.

I. Reactivation from inactive status fee: $200.00.

J. Reactivation from expired status fee: $300.00 ($200.00 plus $100.00 late penalty fee).

K. Duplicate renewal license fee: $25.00.

L. Duplicate of initial wall license fee: $60.00.

M. Written verification of licensure fee: $10.00.

[~~**N.** Administrative fee for application packet: $10.00. Application packet is also downloadable from the board's internet website at no cost.~~

~~**O.** Administrative fee for copy of rules and regulations: $15.00. Application packet is also downloadable from the board's internet website at no cost~~].

~~**P.** Temporary permit for reciprocity applicants: $125.00.~~] [2/24/1988; 9/18/1992; 10/31/1995; 1/10/2000; A, 7/10/2000; A, 8/3/2000; 16.13.2.8 NMAC - Rn & A, 16 NMAC 13.2.8, 1/25/2001; A, 4/15/2002; A, 2/15/2004; A, 2/26/2022, A, 01/14/2023]

REGULATION AND LICENSING DEPARTMENT
NURSING HOME ADMINISTRATORS, BOARD OF

This is an amendment to 16.13.7 NMAC, Sections 2, 9 & 10, effective 01/14/2023

16.13.7.2 SCOPE: [~~The provisions in Part 7 of Chapter 13 apply to all applicants who have met all the requirements, either by examination or by reciprocity, for licensure as a nursing home administrator in New Mexico.~~] The provisions in Part 7 of Chapter 13 apply to all persons to the board of nursing home administrators for licensure in New Mexico.
[10/31/1995; 16.13.7.2 NMAC - Rn, 16 NMAC 13.7.2, 1/25/2001, A, 01/14/2023]

16.13.7.9 [~~APPROVED RECIPROCITY APPLICANT~~: ~~After the applicant has met all the requirements for licensure by reciprocity, and has been approved for licensure by the Board, the Board may issue the applicant an initial license to practice nursing home administration in New Mexico.~~]
[**RESERVED**]
[10/31/1995; 16.13.7.9 NMAC - Rn, 16 NMAC 13.7.9, 1/25/2001, Repealed, 01/14/2023]

16.13.7.10 [~~PRORATED FIRST RENEWAL~~:

~~**A.** All current nursing home administrators licenses will expire on March 31 of the year. Individuals receiving their initial New Mexico nursing home administrators license may be required to renew their license in less than twelve (12) months depending on the first license issue date in order to get into the proper renewal cycle. In such cases, the renewal fee and the continuing education (CE) hours required will be prorated at the first renewal (Same calculation method used in 16.13.13.9 NMAC).~~

~~**B.** The Board will prorate the first renewal fee by multiplying one/twelfth of the annual renewal fee by the number of months from the month of first issuance up to and including the license expiration month (See 16.13.8.8 NMAC).~~]
[**RESERVED**]
[10/31/1995; 16.13.7.10 NMAC - Rn, 16 NMAC 13.7.10, 1/25/2001; A, 04/15/2002; Repealed, 01/14/2023]

REGULATION AND LICENSING DEPARTMENT
OPTOMETRY, BOARD OF

The Board of Optometry approved, at its 12/1/2022 hearing, to repeal 16.16.4 NMAC – Requirements for Licensure by Endorsement, filed 3/15/2001, and replace it with 16.16.4 NMAC - Expedited Licensure, effective 12/27/2022.

The Board of Optometry approved, at its 12/1/2022 hearing, to repeal its rule 16.16.25 NMAC, Licensure for Military Service Members, Spouses and Veterans, filed 3/25/2014, effective 12/27/2022.

REGULATION AND LICENSING DEPARTMENT
OPTOMETRY, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 16 OPTOMETRIC PRACTITIONERS
PART 4 EXPEDITED LICENSURE

16.16.4.1 ISSUING AGENCY: New Mexico Board of Optometry.
[16.16.4.1 NMAC - Rp, 16.16.4.1 NMAC, 12/27/2022]

16.16.4.2 SCOPE: The provisions in Part 4 of Chapter 16 apply to all applicants for expedited licensure.
[16.16.4.2 NMAC - Rp, 16.16.4.2 NMAC, 12/27/2022]

16.16.4.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to the Optometry Act, Sections 61-2-1 to -18 NMSA 1978.
[16.16.4.3 NMAC - Rp, 16.16.4.3 NMAC, 12/27/2022]

16.16.4.4 DURATION : Permanent.
[16.16.4.4 NMAC - Rp, 16.16.4.4 NMAC, 12/27/2022]

16.16.4.5 EFFECTIVE DATE: December 27, 2022, unless a later date is cited at the end of a section.
[16.16.4.5 NMAC - Rp, 16.16.4.5 NMAC, 12/27/2022]

16.16.4.6 OBJECTIVES: The objective of Part 4 is to promote, preserve and protect the public health, safety and welfare by regulating and setting professional standards for applicants for expedited licensure.
[16.16.4.6 NMAC - Rp, 16.16.4.6 NMAC, 12/27/2022]

16.16.4.7 DEFINITIONS:

A. "Eligible jurisdiction" means:

(1) any state or territory of the United States except those included in the list of disapproved licensing jurisdictions in 16.16.4.8 NMAC, and

(2) any foreign country included in 16.16.4.9 NMAC.

B. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

C. "Good standing" means a license or registration is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

D. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-2 NMSA 1978.

E. "Licensing fee" has the same meaning as defined in Paragraph (1) of Subsection E of Section 61-1-34-NMSA 1978.

F. "Military service member" has the same meaning as defined in Paragraph (2) of Subsection E of Sections 61-1-34 NMSA 1978.

G. "Veteran" has the same meaning as defined in Paragraph (3) of Subsection E of Section 61-1-34 NMSA 1978.

[16.16.4.7 NMAC - Rp, 16.16.4.7 NMAC, 12/27/2022]

16.16.4.8 LIST OF DISAPPROVED LICENSING JURISDICTIONS; REASONS. Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Section 61-2-9 of the Optometry Act:

A. American Samoa, on the grounds that education and licensure examination requirements cannot be determined to be consistent with those requirements in New Mexico.

B. Unless the applicant holds both an optometrist license and therapeutic pharmaceutical agents certification, Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Kentucky, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, Northern Mariana Islands, Virgin Islands, and Guam, on the grounds that New Mexico includes the scope of practice for therapeutic pharmaceutical agents certification as part of its optometrist licensing requirements.

[16.16.4.8 NMAC - Rp, 16.16.4.8 NMAC, 12/27/2022]

16.16.4.9 EXPEDITED LICENSURE APPLICATION:

A. A candidate for expedited licensure under Section 61-1-31.1 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application form;

(2) Proof of current licensure in an eligible jurisdiction as defined in these rules;

(3) Certificate of good standing for the license held by the applicant in an eligible jurisdiction;

(4) Payment of the required application fee.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by Subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-2-13 NMSA 1978:

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) The license may not be issued within 30 days of submission of the complete application; and

(3) The board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

[16.16.4.9 NMAC - Rp, 16.16.4.9 NMAC, 12/27/2022]

16.16.4.10 EXPEDITED LICENSURE APPLICATION FOR MILITARY SERVICE MEMBERS AND VETERANS:

A. A candidate for expedited licensure under Section 61-1-34-NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application form;

(2) Proof of current licensure in another jurisdiction;

(3) Certificate of good standing for the license held by the applicant in another jurisdiction, including a branch of the United States armed forces;

(4) Submission of the following documentation:

(a) for military service member: a copy of military orders;

(b) for spouse of military service members: copy of military service member's military orders, and copy of marriage license;

(c) for spouses of deceased military service members: a copy of decedent's DD214 and copy of marriage license;

(d) for dependent children of military service members: a copy of military service member's orders listing dependent child, or a copy of military orders and one of the following; a copy of birth certificate, military service member's federal tax return or other governmental or judicial documentation establishing dependency;

(e) for veterans (retired or separated): a copy of DD214 showing proof of honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a disqualifying criminal conviction

or the board may have other cause to deny the application pursuant to Section 61-2-13-NMSA 1978:

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) The license may not be issued within 30 days of submission of the complete application; and,

(3) The board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged any initial licensing fees or renewal fees for the first three years of licensure with the board.

[16.16.4.10 NMAC - Rp, 16.16.4.10 NMAC, 12/27/2022]

16.16.4.11 EXPEDITED LICENSURE DURATION AND RENEWAL:

A. An expedited license shall be valid for the same length of time as a regular license issued by the board and must be renewed on or before July of each year, as provided by 16.16.10.8 and 9 NMAC.

B. A licensee holding an expedited license may apply for license renewal in the manner provided by the board's rules, provided that upon renewal, the licensee must also satisfy the following examination requirements:

(1) Each licensee shall be required to pass the board's licensing examination, including both the jurisprudence examination and the clinical practicum examination.

(a) At least 10 calendar days prior to examination, the licensee must provide the board a list of the names of any New Mexico licensed optometrists with whom the applicant is acquainted, with whom the applicant has a professional or personal affiliation, or with whom the applicant would feel uncomfortable by being examined. Failure to provide this information prior to the examination may disqualify the candidate from the exam.

(b) The licensee must bring a copy of the board's examination policy and procedures document to the clinical examination and sign it in the presence of the board's representative in attestation that the candidate has read the document. A copy of the document will become a part of the candidate's examination records.

(c) Each candidate will be assigned an identification number that will be the sole means of candidate identification throughout the administration and scoring of the examination.

(d) The licensee must pass each section of the board's licensing examination with a seventy-five percent score or better in order to qualify for renewal.

(2) If the licensee holding an expedited license was not required by the licensee's prior jurisdiction outside of New Mexico to pass the Part 1, Part II, Part III, or the TMOD of the NBEO, the licensee shall be required to do so as a prerequisite to license renewal.

C. Upon renewal, the board shall issue a regular license to a licensee holding an expedited license issued pursuant to these rules.

[16.16.4.11 NMAC - Rp, 16.16.4.11 NMAC, 12/27/2022]

HISTORY of 16.16.4 NMAC:

Pre-NMAC History:

Material in the part was derived from that previously filed with the commission of public records - state records center and archives:
OEB 73-1, Rule No. 1 of the Administrative Rules and Regulations of the State Board of Examiners in Optometry, filed 10/18/1973.
NMBO Rule 8, Board Rule No. 8 - Licensure By Endorsement, filed 3/1/1991.
NMBO Rule 8, Board Rule No. 8 - Licensure By Endorsement, filed 7/22/1992.
NMBO Rule 8, Board Rule No. 8 - Licensure By Endorsement, filed 5/25/1994.

History of Repealed Material:
16.16.4 NMAC – Requirements for Licensure by Endorsement, filed 3/15/2001 was repealed and replaced by 16.16.4 NMAC - Expedited Licensure, effective 12/27/2022.

Other History:
16 NMAC 16.4, Requirements For Licensure By Endorsement, filed 9/21/1995, replaced NMBO Rule 8, Board Rule No. 8 - Licensure By Endorsement. Filed 5/25/1994.
16 NMAC 16.4, Requirements For Licensure By Endorsement, filed 9/21/1995, was renumbered and reformatted to 16.16.4 NMAC, Requirements For Licensure By Endorsement, effective 3/15/2001.

REGULATION AND LICENSING DEPARTMENT
OPTOMETRY, BOARD OF

This is an amendment to 16.16.2 NMAC, Sections 2, 3, 8, 9, 10, 11 and 23, effective 12/27/2022.

16.16.2.2 SCOPE:
[~~Provisions~~] The provisions in Part 2 of Chapter 16 apply to all licensed optometrists, applicants for optometric licensure in New Mexico, anyone wishing to purchase licensee lists or mailing labels, or anyone who requests a written verification of licensure to be completed by the board.

[10/14/1995; 16.16.2.2 NMAC - Rn, 16 NMAC 16.2.2, 3/15/2001; A, 12/27/2022]

16.16.2.3 STATUTORY AUTHORITY: [~~The authority for Part 2 of Chapter 16 is NMSA 1978, Sections 61-2-11, 61-2-6.D. (1) and (2) (1995 Repl. Pamp.).~~] These rules are promulgated pursuant to the Optometry Act, Sections 61-2-1 to 61-2-18 NMSA 1978.

[6/24/1994; 10/14/1995; 16.16.2.3 NMAC - Rn, 16 NMAC 16.2.3, 3/15/2001; A, 12/27/2022]

16.16.2.8 APPLICATION PROCESSING FEE: $175.00

A. The application fee must accompany the letter of intent to sit for a scheduled [~~exam~~] board examination for the purposes of 16.16.3.9 [~~and 16.16.4.8~~] NMAC.

B. The application-processing fee is required each time the candidate [~~is scheduled~~] applies to sit for the board [~~exam~~] examination.
[6/24/1994; 10/14/1995; 5/31/1996; 16.16.2.8 NMAC - Rn, 16 NMAC 16.2.8, 3/15/2001; A, 7/6/2012; A, 12/27/2022]

16.16.2.9 EXAMINATION FEE: $400.00. The examination fee is required each time the candidate is scheduled for the board [~~exam~~] examination.
[6/24/1994; 10/14/1995; 5/31/1996; 16.16.2.9 NMAC - Rn, 16 NMAC 16.2.9, 3/15/2001; A, 12/27/2022]

16.16.2.10 LICENSE FEE FOR [~~EXAM~~] EXAMINATION CANDIDATES: $200.00. The license fee is required after passing the board examination in order to receive an initial license.
[6/24/1994; 10/14/1995; 5/31/1996; A, 6-26-00; 16.16.2.10 NMAC - Rn, 16 NMAC 16.2.10, 3/15/2001; A, 07/06/2012; A, 12/27/2022]

16.16.2.11 EXPEDITED LICENSE FEE [~~FOR ENDORSEMENT CANDIDATES~~]: $250.00. The expedited license fee is required with an expedited license application in order to submit an application and receive an initial license.
[6/24/1994; 10/14/1995; 5/31/1996; A, 6-26-00; 16.16.2.11 NMAC - Rn, 16 NMAC 16.2.11, 3/15/2001; A 07-06-2012; A, 12/27/2022]

16.16.2.23 OTHER ADMINISTRATIVE FEES:

[~~**A. Application packet**: $10.00. The license application packet is also downloadable at no cost from the board's internet website at www.rld.state.nm.us.~~

~~**B. Hard copy of board's rules and regulations and statute**: $15.00. These documents are available and downloadable at no cost from the board's internet website at www.rld.state.nm.us.~~

~~**C. Request for CE review for approval for licensees**~~]
Request for CE review for approval for licensees as provided in 16.16.13.10 NMAC: $35.00
[16.16.2.23 NMAC - Rn, 16.16.2.21 NMAC, 07-06-2012; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
OPTOMETRY, BOARD OF

This is an amendment to 16.16.3 NMAC, Sections 2, 3, 6, 8, 9 and 10, effective 12/27/2022.

16.16.3.2 SCOPE: The provisions in Part 3 of Chapter 16 apply to any applicant for optometric licensure in New Mexico who does not meet the requirements for expedited licensure [~~by endorsement~~].
[10/14/1995; 16.16.3.2 NMAC - Rn, 16 NMAC 16.3.2, 3/15/2001; A, 12/27/2022]

16.16.3.3 STATUTORY AUTHORITY: [~~The authority for Part 3 of Chapter 16 is Section 61.2.4 NMSA 1978; Subsections B and D of 61-2-6 NMSA 1978; Section 61-2-8 NMSA 1978; and Section 61-2-9 NMSA 1978 (1995 Repl. Pamp.).~~]
These rules are promulgated pursuant to the Optometry Act, Sections 61-2-1 to -18 NMSA 1978.
[11/17/1973; 3/31/1991; 8/21/1992; 6/24/1994; 10/14/1995; 16.16.3.3 NMAC - Rn, 16 NMAC 16.3.3, 3/15/2001; A, 2/26/2022; A, 12/27/2022]

16.16.3.6 OBJECTIVE: The objective of Part 3 of Chapter 16 is to establish [~~clearly the licensure application~~] procedures and requirements for [~~candidates who are~~] applicants seeking licensure by examination to qualify to sit for the board's licensing examination.
[10/14/1995; 16.16.3.6 NMAC - Rn, 16 NMAC 16.3.6, 3/15/2001; A, 12/27/2022]

16.16.3.8 EXAMINATION REQUIREMENTS:

A. [~~As of January 15, 1995, all candidates~~] All applicants for licensure by examination are required to take the board's licensing examination.

B. [~~As of January 15, 1995, **all** candidates, except those who have met the qualification requirements set forth in Subsections A and B of 16.16.4.8 NMAC and have been approved as candidates for licensure by endorsement,~~]
All applicants for licensure by examination shall be required to pass Part I, Part II, Part III, and the TMOD of the NBEO national standards examination as a prerequisite to sitting for the board's licensing examination.
[10/14/1995, 5/31/1996, 2/15/1999; 16.16.3.8 NMAC - Rn, 16 NMAC 16.3.8, 3/15/2001; A, 12/27/2022]

16.16.3.9 APPLICATION REQUIREMENTS: In accordance with Section 61-2-8 NMSA 1978, and those qualifications set forth therein, [~~candidates~~] applicants for licensure by examination must submit to the board office, at least 65 days prior to the announced examination date, a letter of intent applying for the next regularly scheduled board examination accompanied by the required application processing fee. In addition to a completed, board-approved application form, the following documents must be received by the board office no later than 40 days prior to the requested examination.

[~~**A.** Letters of reference from two currently licensed optometrists actively engaged in the practice of optometry, and not related to the applicant, written on their letterhead stationery.~~]

[~~**B**~~] **A.** Official pre-optometry transcript(s) sent directly

to the board office by each college or university attended by the applicant.

[~~C~~] **B.** A complete official optometry transcript showing the applicant's graduation sent directly to the board by a college of optometry as approved by the American optometric association's council of optometric education.

(1) An applicant expecting to graduate in the spring or summer prior to the board's examination who does not expect completed transcripts to be available before the documentation deadline, must make arrangements for the school to send a letter directly to the board regarding the applicant's expected graduation.

(2) The letter must be postmarked before the forty-day documentation deadline.

(3) The completed, official transcript must be received by the board before the scheduled examination date or the application will be considered incomplete, and the applicant will be denied entrance into the examination.

[~~D~~] **C.** [~~A statement and copy of other~~] Verification of another state license[~~(s)~~] held by the applicant, if applicable.

[~~E. A recent, passport-type photograph of the applicant.~~]

[~~F~~] **D.** An affidavit from the applicant that the applicant has not engaged in any optometry practice of an illegal or unethical nature as defined in the [~~New Mexico Optometry Act, NMSA 1978, Sections 61-2-1 to 61-21-18 (1995 Repl. Pamp.).~~] Optometry Act, Sections 61-2-1 to-18 NMSA 1978.

[~~G~~] **E.** Copy of current certification attesting to completion of a CPR course offered by the American red cross, the American heart association, or the American safety and health institute (ASHI). The course cannot be self-study.

[~~H~~] **F.** A verification from an accredited optometry school of successful completion of 100 or more post-graduate clock hours of ocular therapeutics pharmacology, as provided in Subsection A of 16.16.7.10 NMAC, and a minimum of 20 post-graduate clock hours in clinical pharmacology as provided in Subsection B of 16.16.7.11 NMAC.

[~~I~~] **G.** Verification directly from the national board of examiners in optometry (NBEO) that the applicant has successfully passed part I, part II, part III, and the TMOD of the NBEO as provided in Subsection B of 16.16.3.8 NMAC.

(1) If NBEO examination results will not be released by the NBEO prior to the documentation deadline, the applicant must submit to the board a copy of the NBEO letter scheduling the applicant for the NBEO exam(s).

(2) Upon receipt of verification of successful completion of the required NBEO exam(s), and upon having met all other requirements stipulated in this regulation, the approved [~~candidate~~] applicant will be scheduled for the next regularly scheduled board examination.

[~~J~~] **H.** A list of the names of any New Mexico licensed optometrist(s) with whom the applicant is acquainted; with whom the applicant has a professional or personal affiliation; or that the applicant would feel uncomfortable being examined by, in the event that one of those optometrists is a board member or a clinical examiner for the board. Failure to provide this information prior to the examination deadline may disqualify the [~~candidate~~]applicant from the exam.

[~~K~~] **I.** Each approved exam [~~candidate~~] applicant will be required to bring [~~their~~] a copy of the board's [~~exam~~] examination policy and procedures document to the clinical exam and to sign it in the presence of the board's representative in attestation that the [~~candidate~~] applicant has read the document; and a copy of the document will become a part of the candidate's examination records.

[~~L~~] **J.** proof of any disqualifying criminal convictions as defined in 16.16.21.12 NMAC.

[11/17/1973; 3/8/1986; 3/31/1991; 8/21/1992; 6/24/1994; 9/30/1995; 10/14/1995; 5/31/1996; 2/15/1999; 16.16.3.9 NMAC - Rn, 16 NMAC 16.3.9, 3/15/2001; A, 3/15/2004; A, 3/22/2008; A, 7/6/2012; A, 6/25/2015, A, 2/26/2022; A, 12/27/2022]

16.16.3.10 APPLICATION APPROVAL: Upon board review and approval of the above listed documentation, each approved candidate will be scheduled by letter to sit for the board's examination.

A. [~~Candidates~~] Applicants will not be allowed entrance into the examination without this schedule notification letter.

B. At least one form of picture identification will be required for entrance into the examination.

C. Each [~~candidate~~] applicant will be assigned an identification number that will be the sole means of [~~candidate~~] applicant identification throughout the administration and scoring of the examination.

[10/14/1995; A, 2/15/1999; 16 NMAC 16.3.10 - Rn, 16 NMAC 16.3.10, 3/15/2001; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT

OPTOMETRY, BOARD OF

This is an amendment to 16.16.10 NMAC, Sections 3 and 8, effective 12/27/2022.

16.16.10.3 STATUTORY AUTHORITY: [~~The authority for Part 10 of Chapter 16 is Subsection D of 61-2-6 NMSA 1978; Section 61-2-12 NMSA 1978; and Subsection A of Section 61-2-14 NMSA 1978;(1995 Repl. Pamp.).~~] These rules are promulgated pursuant to the Optometry Act, Sections 61-2-1 to-18 NMSA1978.

[10/14/1995; 16.16.10.3 NMAC - Rn, 16 NMAC 16.10.3, 3/15/2001, A, 2/26/2022; A, 12/27/2022]

16.16.10.8 LICENSE EXPIRATION DATE: All current New Mexico optometry licenses not renewed by July 1 of every year shall be considered expired. Initial licenses

may be issued for a period greater than 12 months, but less than 24 months, in order to align the license expiration date with the renewal cycle.
[10/14/1995; 16.16.10.8 NMAC - Rn, 16 NMAC 16.10.8, 3/15/2001; A, 3/22/2008; A, 7/6/2012; A, 12/27/2022]

REGULATION AND LICENSING DEPARTMENT
PSYCHOLOGIST EXAMINERS, BOARD OF

The Regulation and Licensing Department, Board of Psychologist Examiners approved, at its 12/09/2022 hearing, to repeal its rule 16.22.14 NMAC, Licensure For Military Service Members, Spouses and Veterans, filed 4/30/2015, and replace with 16.22.14 NMAC Expedited Licensure, effective 01/08/2023.

REGULATION AND LICENSING DEPARTMENT
PSYCHOLOGIST EXAMINERS, BOARD OF

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 14 EXPEDITED LICENSURE

16.22.14.1 ISSUING AGENCY: Regulation and Licensing Department Psychologist Examiners Board.
[16.22.14.1 NMAC – Rp, 16.22.14.1 NMAC, 1/08/2023]

16.22.14.2 SCOPE: The provisions in Part 14 of Chapter 22 apply to all applicants for expedited licensure.
[16.22.14.2 NMAC – Rp, 16.22.14.2 NMAC, 1/08/2023]

16.22.14.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to Professional Psychologists Act, NMSA 1978.
[16.22.14.3 NMAC – Rp, 16.22.14.3 NMAC, 1/08/2023]

16.22.14.4 DURATION: Permanent.
[16.22.14.4 NMAC – Rp, 16.22.14.4 NMAC, 1/08/2023]

16.22.14.5 EFFECTIVE DATE: January 8, 2023, unless a later date is cited at the end of a section.
[16.22.14.5 NMAC – Rp, 16.22.14.5 NMAC, 1/08/2023]

16.22.14.6 OBJECTIVE: The objective of Part 14 is to promote, preserve and protect the public health, safety and welfare by regulating and setting professional standards for applicants for expedited licensure.
[16.22.14.6 NMAC – Rp, 16.22.14.6 NMAC, 1/08/2023]

16.22.14.7 DEFINITIONS:

A. "Eligible jurisdiction" means:

(1) any stat or territory of the United States except those included in the list of disapproved licensing jurisdictions in 16.22.14.8 NMAC; and

(2) any foreign country included in 16.22.15.9 NMAC.

B. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board. license or registration is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

C. "Good standing" means a license or registration is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

D. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-2 NMSA 1978.

E. "Licensing fee" has the same meaning as defined in Paragraph (1) of Subsection E of Section 61-1-34 NMSA 1978.

F. "Military service member" has the same meaning as defined in Paragraph (2) of Subsection E of Section 61-1-34 NMSA 1978,

G. "Qualified applicant" means an applicant who:

(1) holds a current license in good standing in another jurisdiction, provided that an applicant who is not a military service member or veteran must hold a current license in good standing in an eligible jurisdiction;

(2) does not have a disqualifying criminal conviction, as defined the board's rules, and

(3) is not subject to pending disciplinary action in New Mexico.

H. "Substantially equivalent" means the determination by the board that the education, examination, and experience requirements contained in the statutes and rules of another jurisdiction are comparable to or exceed the education, examination, and experience requirements of the Professional Psychology Act, NMSA 1978.

I. "Veteran" has the same meaning as defined in Paragraph (3) or Subsection E of Section 61-1-34 NMSA 1978.
[16.22.14.7 NMAC – Rp, 16.22.14.7 NMAC, 1/08/2023]

16.22.14.8 LIST OF DISAPPROVED LICENSING JURISDICTIONS; REASONS:

A. Applicants for licensure as a doctoral level psychologist licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Section 61-9-10 NMSA 1978.

B. Applicants for expedited licensure are required to

have been licensed in a previous jurisdiction for two years, be in good standing, have no pending or active complaints, and are otherwise in compliance with all psychology licensure requirements in New Mexico as referenced in 16.22.14.7 NMAC.

(1) The following jurisdictions, on the grounds that they do not require accreditation by a nationally recognized accreditation body as defined in Subsection A of 16.22.1.7 NMAC are not consistent with New Mexico's requirements:

(a) Alaska;

(b) Arizona;

(c) Arkansas;

(d) California;

(e) Colorado;

(f) Florida:

(g) Hawaii;

(h) Idaho;

(i) Indiana;

(j) Kansas;

(k) Kentucky;

(l) Massachusetts:

(m) Minnesota:

(n) Missouri;

(o) Nebraska;

(p) Nevada;

(q) North Carolina;

(r) Ohio;

(s) Oregon;

(t) South Dakota;

(u) Texas;

(v) Utah;

(w) Vermont;

(x) Virginia;

(y) Washington;

(z) West Virginia;

(aa) Wisconsin;

(bb) Wyoming;

(cc) Connecticut;

(dd) Delaware;

(ee) Illinois;

(ff) Louisiana;

(gg) Maine;

(hh) New Hampshire;

(ii) New Jersey;

(jj) Rhode Island

(2) It is important to note that requirements for licensure are based on the individual applicant's qualifications, educational training, clinical supervision and other requirements as consistent with the New Mexico Board of Psychologists Examiners statute and rules, rather than the jurisdiction in which the applicant was last licensed.

(3) The following jurisdictions, on the grounds that they do not specify the type of practicum, doctoral internship, and postdoctoral supervised experience required, consistent with 16.22.6.8 NMAC, are not consistent with New Mexico's requirements:

(a) Alaska;

(b) Arizona;

(c) Colorado;

(d) Georgia;

(e) Kentucky;

(f) Maine;

(g) Massachusetts:

(h) Michigan;

(i) Mississippi;

(j) Missouri;

(k) Nevada;

(l) New Hampshire;

(m) North Dakota;

(n) Ohio;

(o) Pennsylvania;

(p) South Dakota;

(q) Utah;

(r) Virginia;

(s) Washington;

(t) West Virginia;

(u) Wisconsin;

(v) Wyoming;

(4) The following jurisdictions, on the grounds that they do not require the EPPP or passing the EPPP at the specified level 16.22.7.8 NMAC;

(a) Guam;

(b) Puerto Rico.

C. Applicants for certification as prescribing psychologist licensed or certified in the following states and territories of the United States shall not be eligible for expedited licensure under Section 61-9-10 NMSA 1978:

(1) The following jurisdictions on the grounds that licensure or certification for prescribing is not allowed:

(a) Alabama;

(b) Alaska;

(c) Arizona;

(d) Arkansas;

(e) California;

(f) Colorado;

(g) Connecticut;

(h) Delaware;

(i) District of Columbia;

(j) Florida;

(k) Georgia;

(l) Hawaii;

(m) Indiana;

(n) Kansas;

(o) Kentucky;

(p) Maine;

(q) Maryland;

(r) Massachusetts;

(s) Michigan;

(t) Minnesota;

(u) Mississippi;

(v) Missouri;

(w) Montana;

(x) Nebraska;

(y) Nevada;

(z) New Hampshire;

(aa) New Jersey;

(bb) New York;

(cc) North Carolina;

(dd) North Dakota;

(ee) Ohio;

(ff) Oklahoma;

(gg) Oregon;

(hh) Pennsylvania;

(ii) Rhode Island;

(jj) South Carolina;

(kk) South Dakota;

(ll) Tennessee;

(mm) Texas;

(nn) Utah;

(oo) Vermont;

(pp) Virginia;

(qq) Washington;

(rr) West Virginia;

(ss) Wisconsin;

(tt) Wyoming;

(uu) American Samoa;

(vv) Guam;

(ww) Northern Mariana Islands; and

(xx) U.S. Virgin Islands.

(2) The following jurisdiction on the grounds that the *Psychopharmacology Examination for Psychologists* (PEP) is not required:

(a) Guam;

(b) Puerto Rico.

(3) The following jurisdictions on the ground that required psychopharmacology training, supervision or experience is not equivalent to that required by New Mexico (16.22.23 NMAC):

(a) Guam

(b) Idaho

(c) Illinois

(d) Iowa

(e) Louisiana

(f) Puerto Rico

[16.22.14.8 NMAC – Rp, 16.22.14.8 NMAC, 1/08/2023]

16.22.14.9 LIST OF APPROVED FOREIGN JURISDICTIONS: No applicants licensed in countries outside of the United States are eligible for expedited licensure under Section 61-9-10 NMSA 1978.

[16.22.14.9 NMAC - N, 1/08/2023]

16.22.14.10 EXPEDITED LICENSURE APPLICATION:

A. A candidate for expedited licensure under Section 61-1-31.1 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application form;

(2) proof of a current license in good standing in an eligible jurisdiction as defined in these rules;

(3) payment of the required application fee;

(4) two years of practice as a licensed psychologist or prescribing psychologist; and

(5) proof of national criminal history screening Subsection C of 16.22.5.8 NMAC.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by Subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal

conviction or the board may have other cause to deny the application pursuant to Section 61-9-13 NMSA 1978 and 16.22.2.20 NMAC:

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

[16.22.14.10 NMAC – Rp, 16.22.14.10 NMAC, 1/08/2023]

16.22.14.11 EXPEDITED LICENSURE APPLICATION FOR MILITARY SERVICE MEMBERS AND VETERANS:

A. A candidate for expedited licensure under Section 61.1.34 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application form;

(2) proof of a current license in good standing in another jurisdiction, including a branch of the United States armed forces; and

(3) submission of the following documentation:

(a) for military service member: a copy of military orders;

(b) for spouse of military service members: copy of military service member's military orders, and copy of marriage license;

(c) for spouses of deceased military service members: copy of decedent's DD 214 and copy of marriage license;

(d) for dependent children of military service members: a copy of military service member's orders listing dependent child, or a copy of military orders and one of the following: a copy of birth certificate, military service member's federal tax return or other governmental or judicial documentation establishing dependency; or

(e) for veterans (retired or separated): proof of honorable discharge such as a copy of DD Form 214, DD Form 215, DD Form 256, DD Form 257, NGB Form 22, military ID card, a driver's license or state ID card with a veteran's designation, or other documentation verifying honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by Subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-9-13 NMSA 1978 and 16.22.12.20 NMAC:

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged a licensing fee for the first three years of licensure with the board.

[16.22.14.11 NMAC – N, 1/08/2023]

16.22.14.12 EXPEDITED LICENSE DURATION AND RENEWAL:

A. An expedited license shall be valid for the same length of time as a regular initial license issued by the board.

B. A licensee holding an expedited license may apply for license renewal in the manner provided by the board's rules, provided that, if the licensee holding an expedited license was not required by the licensee's original jurisdiction outside of New Mexico to pass exams pursuant to Professional Psychology Act, the licensee shall be required to pass the examination prior to renewing the license.

C. Upon renewal, the board shall issue a regular license to a licensee holding an expedited license issued pursuant to these rules.

[16.22.14.12 NMAC – N, 1/08/2023]

HISTORY OF 16.22.14 NMAC:

16.22.14 NMAC - Licensure For Military Service Members, Spouses and Veterans, filed 4/30/2015 was repealed and replaced by 16.22.14 NMAC – Expedited Licensure, effective 1/08/2023.

REGULATION AND LICENSING DEPARTMENT

PSYCHOLOGIST EXAMINERS, BOARD OF

This is an amendment to 16.22.2 NMAC, Sections 8 and 19, effective 1/08/2023.

16.22.2.8 RULES OF COMPETENCE:

A. Limits on practice. The psychologist shall limit practice and supervision to the areas of competence in which proficiency has been gained through education, training, and experience.

B. Maintaining competency. The psychologist shall maintain current competency in the areas in which he practices, through continuing professional education, consultation, and/or other procedures,

in conformance with current standards of scientific and professional knowledge.

C. Cultural competency. Psychologists with restricted and unrestricted licenses and psychologist associates shall complete eight hours of cultural competence coursework promulgated by the board during the first year of licensure; and also shall take four additional hours in cultural competence, as deemed satisfactory to the board, every two years as detailed in 16.22.9 NMAC.

D. Adding new services and techniques. The psychologist, when developing competency in a service or technique that is either new to the psychologist or new to the profession, shall engage in ongoing consultation with other psychologists or relevant professionals, and shall seek appropriate education and training in the new area. The psychologist shall inform clients or patients of the innovative nature and the known risks and benefits associated with the services, so that the client or patient can exercise freedom of choice concerning such services.

E. Referral. The psychologist shall make or recommend referral to professional, technical, or administrative, or public resources when such referral is clearly in the best interest of the clients or patient(s).

F. Bases for assessments. Psychologists base the opinions contained in their recommendations, reports and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings except when:

(1) psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions;

(2) despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions and appropriately limit the nature and extent of their conclusions or recommendations; or

(3) psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

G. Maintenance and retention of records.

(1) The psychologist rendering professional services to a client or patient shall maintain professional records that include:

(a) the presenting problem(s) or the reason the client(s) or patient(s) sought the psychologist's services;

(b) diagnosis [~~and/or~~] and clinical formulation;

(c) the fee arrangement;

(d) the date and substance of each billed contact or service;

(e) any test results or other evaluative results obtained and any basic test data from which they were derived;

(f) notation and results of formal consultations with other providers;

(g) a copy of all test or other evaluative reports prepared as part of the professional relationship;

(h) the date of termination of services.

(2) The psychologist shall ensure that all data entries in the professional records are maintained for a period of not less than five years after the last date that service was rendered. The psychologist shall comply with other legal requirements for record retention, even if longer periods of retention are required for other purposes.

(3) The psychologist shall store and dispose of written, electronic, and other records in a manner that protects confidentiality.

(4) For each person professionally supervised, the psychologist shall maintain for a period of not less than five years after the last date of supervision a record of the supervisory session that shall include, among other information, the type, place, and general content of the session.

(5) Upon request by the client, patient, or legal representative of the client or patient, the psychologist shall release records under his control, except as otherwise provided in these rules and regulations or state law. Lack of payment for services does not constitute grounds for refusing to release client or patient records.

[16.22.2.8 NMAC - Rp, 16.22.2.8 NMAC, 11/15/2006; A, 9/16/2010; A, 7/1/2018; A, 1/08/2023]

16.22.2.19 RESOLVING ETHICAL ISSUES:

A. Improper complaints. The psychologist shall not file or encourage the filing of ethics complaints to the board that are frivolous.

B. Familiarity with this code. The psychologist has an obligation to be familiar with the code, other applicable ethics codes, and their application to psychologists' work. Lack of awareness or misunderstanding of the code is not a defense to a charge of unethical conduct.

C. Confronting ethical issues. When a psychologist is uncertain whether a particular situation or course of action would violate this code, the psychologist shall consult with other psychologists knowledgeable about ethical issues, with state or national psychology ethics committees, or with other appropriate authorities in order to choose a proper course of action. Such consultation is not a defense to a charge of unethical conduct.

D. Mandatory reporting. If a psychologist has reason to believe that another psychologist is engaged in a prohibited dual relationship with a client or patient, exhibits habitual or excessive use of drugs and alcohol that adversely affect professional practice or commits fraud or gross incompetence, the psychologist must report the suspected violation to the board. The psychologist shall not violate patient confidentiality in order to make a report to the board regarding another psychologist's behavior. The psychologist may disclose such information without the patient's consent in urgent situations as described in Subsection C of 16.22.2.12 NMAC.

E. Cooperating with complaint and ethics committees. The psychologist shall cooperate in investigations, proceedings, and requirements of this code, the ethical principles of psychologists and code of conduct of the American psychologist association, or any affiliated state psychological association to which he belongs. In doing so, the psychologist shall make reasonable efforts to resolve any issues of confidentiality. Failure to cooperate is a separate violation of the code.

[16.22.2.19 NMAC - Rp, 16.22.2.19 NMAC, 11/15/2006; A, 1/08/2023]

REGULATION AND LICENSING DEPARTMENT
PSYCHOLOGIST EXAMINERS, BOARD OF

This is an amendment to 16.22.5 NMAC, Section 8, effective 01/08/2023.

16.22.5.8 APPLICATION; EXAMINATION; PROCESS:

A. A non-refundable application fee set by the board is due at the time of each initial application. Additional fees may be charged and will be collected by the board, as necessary, for the administration of examinations.

B. The applicant may be considered for licensure if the applicant fulfills conditions of 16.22.4 NMAC, 16.22.6 NMAC, and 16.22.7 NMAC. The board will develop, approve, [~~and~~] maintain and post on its website a list of American and Canadian jurisdictions whose requirements of education, supervised experience and EPPP passing score do not meet [~~or exceed~~] those of 16.22.4 NMAC, 16.22.6 NMAC and Paragraph (1) of Subsection A of 16.22.7.8 NMAC. The board shall include a statement of the specific licensure requirement not met for each jurisdiction on the list. 16.22.14 NMAC. The only exceptions to these requirements apply to [~~foreign trained individuals~~] applicants who are graduates from programs outside the United States and Canada as defined in 16.22.5.15 NMAC.

C. Nationwide criminal history screening: All applicants for initial licensure in any category in New Mexico are subject to a national criminal history screening at their expense. All applicants must register with the New Mexico department of public safety's fingerprinting vendor, pay the fingerprint processing fee and submit fingerprints in accordance with the vendor's established process. Background check results will be sent directly to the board office electronically.

(1) Applications for licensure will not be approved without submission of fingerprints criminal background screening and fee.

(2) Applications will be processed pending the completion of the nationwide criminal background screening.

(3) If the criminal background screening reveals a disqualifying criminal conviction, the applicant/licensee will be notified to submit copies of legal documents and other related information to the board which will make the determination if the applicant is eligible for licensure or if disciplinary action will be taken.

(4) Applications not completed and approved within 24 months from the date application is received in the board office shall become null and void and the applicant shall submit a new application.

[16.22.5.8 NMAC - Rp, 16.22.5.9 NMAC, 11/15/06; A, 9/16/10; A, 4/11/2012; A, 7/1/2018; A, 01/08/2023]

REGULATION AND LICENSING DEPARTMENT
SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID DISPENSING PRACTICES BOARD

The Regulation and Licensing Department, Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Board approved, at its 12/12/2022 hearing, to repeal its rule 16.26.10 NMAC, Emergency Licensure, filed 11/09/2005, effective 12/08/2023.

The Regulation and Licensing Department, Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Board approved, at its 12/12/2022 hearing, to repeal its rule 16.22.11 NMAC, Licensure for Military service Members, Spouses and Veterans, filed 1/29/2015, effective 1/08/2023.

REGULATION AND LICENSING DEPARTMENT
SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID DISPENSING PRACTICES BOARD

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 26 HEARING, SPEECH AND AUDIOLOGY PRACTITIONERS
PART 10 EXPEDITED LICENSURE

16.26.10.1 ISSUING AGENCY: New Mexico Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Board.
[16.26.10.1 NMAC - Rp, 16.26.10.1 NMAC, 01/08/2023]

16.26.10.2 SCOPE: The provisions in Part 10 of Chapter 26 apply to all applicants for expedited licensure.
[16.26.10.2 NMAC - Rp, 16.26.10.2 NMAC, 01/08/2023]

16.26.10.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to the Speech-Language Pathology and Audiology and Hearing Aid Dispensing Practices Act, (Sections 61-14B-1 to 61-14B-25 NMSA 1978) and the Uniform Licensing Act NMSA 1978 (Sections 61-1-1 to 61-1-37).
[16.26.10.3 NMAC - Rp, 16.26.10.3 NMAC, 01/08/2023]

16.26.10.4 DURATION: Permanent.
[16.26.10.4 NMAC - Rp, 16.26.10.4 NMAC, 01/08/2023]

16.26.10.5 EFFECTIVE DATE: January 8, 2023, unless a later date is cited at the end of a section.
[16.26.10.5 NMAC - Rp, 16.26.10.5 NMAC, 01/08/2023]

16.26.10.6 OBJECTIVE: The objective of Part 10 is to promote, preserve and protect the public health, safety and welfare by regulating and setting professional standards for applicants for expedited licensure.
[16.26.10.6 NMAC - Rp, 16.26.10.6 NMAC, 01/08/2023]

16.26.10.7 DEFINITIONS:

A. "Eligible jurisdiction" means:

(1) any state or territory of the United States except those included in the list of disapproved licensing jurisdictions in 16.26.10.8 NMAC; and

(2) any foreign country included in 16.26.10.9 NMAC.

B. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

C. "Good standing" means a license or registration is active and not expired, suspended, revoked, surrendered, conditioned, or otherwise in a status that in any manner restricts the activity of a licensee or registrant under the authority of the license.

D. "Jurisdiction" has the same meaning as defined in Subsection F of Section 61-1-2 NMSA 1978.

E. "Licensing fee" has the same meaning as defined in Paragraph (1) of Subsection E of Section 61-1-34 NMSA 1978.

F. "Military service member" has the same meaning as defined in Paragraph (2) of Subsection E of Section 61-1-34 NMSA 1978.

G. "Qualified applicant" means an applicant who:

(1) holds a current license in good standing in another jurisdiction, provided that an applicant who is not a military service member or veteran must hold a current license in good standing in an eligible jurisdiction;

(2) does not have a disqualifying criminal conviction, as defined by the board's rules; and

(3) is not subject to pending disciplinary action in New Mexico.

H. "Veteran" has the same meaning as defined in Paragraph (3) Subsection E of Section 61-1-34 NMSA 1978.
[16.26.10.7 NMAC - Rp, 16.26.10.7 NMAC, 01/08/2023]

16.26.10.8 LIST OF DISAPPROVED LICENSING JURISDICTIONS; REASONS: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Section 61-14B-16.1 NMSA 1978, of the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act:

A. Speech-language pathologist: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Section 61-14B-16.1 NMSA 1978, of the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act: American Samoa, Northern Mariana Islands, and the U.S. Virgin Islands, on that grounds that these jurisdictions do not regulate this profession.

B. Audiologist: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Section 61-14B-16.1 NMSA 1978, of the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act:

(1) Alaska, Arkansas, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Illinois, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New York, Puerto Rico, South Dakota, Vermont, Washington, West Virginia, on that grounds that these jurisdictions have multiple pathways to licensure that do not meet New Mexico's education and examination requirements.

(2) American Samoa, Northern Mariana Islands, and the U.S. Virgin Islands, on the grounds that these jurisdictions do not regulate this profession.

C. Hearing aid dispenser: Applicants licensed in the following states and territories of the United States shall not be eligible for expedited licensure under Section 61-14B-16.1 NMSA 1978, of the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act:

(1) Alaska, California, District of Columbia, and Idaho, on that grounds that these jurisdictions do not have training and/or examination requirements consistent with New Mexico.

(2) American Samoa, Guam, Northern Mariana

Islands, Puerto Rico, and the U.S. Virgin Islands, on the grounds that these jurisdictions do not regulate this profession.
[16.26.10.8 NMAC - Rp, 16.26.10.8 NMAC, 01/08/2023]

16.26.10.9 LIST OF APPROVED FOREIGN JURISDICTIONS: [RESERVED]

16.26.10.10 EXPEDITED LICENSURE APPLICATION:

A. A candidate for expedited licensure under Section 61-1-31.1 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application form;

(2) proof of a current license in good standing in an eligible jurisdiction as defined in these rules; and

(3) payment of the required application fee.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by Subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-14B-21 NMSA 1978:

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.
[16.26.10.10 NMAC – N, 01/08/2023]

16.26.10.11 EXPEDITED LICENSURE APPLICATION FOR MILITARY SERVICE MEMBERS AND VETERANS:

A. A candidate for expedited licensure under Section 61-1-34 NMSA 1978 must submit to the board a complete application containing all of the following:

(1) A completed and signed application form;

(2) proof of a current license in good standing in another jurisdiction, including a branch of the United States armed forces; and

(3) submission of the following documentation:

(a) for military service member: a copy of military orders;

(b) for spouse of military service members: copy of military service member's military orders, and copy of marriage license;

(c) for spouses of deceased military service members: copy of decedent's DD 214 and copy of marriage license;

(d) for dependent children of military service members: a copy of military service member's orders listing dependent child, or a copy of military orders and one of the following: a copy of birth certificate, military service member's federal tax return or other governmental or judicial documentation establishing dependency; or

(e) for veterans (retired or separated): proof of honorable discharge such as a copy of DD Form 214, DD Form 215, DD Form 256, DD Form 257, NGB Form 22, military ID card, a driver's license or state ID card with a veteran's designation, or other documentation verifying honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted, and the board's staff is in receipt of, all of the materials required by subsection A, including documentation from third parties.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal conviction or the board may have other cause to deny the application pursuant to Section 61-14B-21 NMSA 1978:

(1) The matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the board may vote to grant the application or refer the matter to its administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged a licensing fee for the first three years of licensure with the board.
[16.26.10.11 NMAC – N, 01/08/2023]

16.26.10.12 EXPEDITED LICENSE DURATION AND RENEWAL:

A. An expedited license shall be valid for the same length of time as a regular initial license issued by the board.

B. A licensee holding an expedited license may apply for license renewal in the manner provided by the board's rules provided that, upon renewal, the licensee must also satisfy the following examination requirements:

(1) The licensee shall be required to pass the New Mexico jurisprudence examination.

(2) For speech-language pathologists, if the licensee holding an expedited license was not required by the licensee's original jurisdiction outside of New Mexico to pass a nationally recognized standard examination in speech-language pathology, the licensee shall be required to pass the examination prior to renewing the license.

(3) For audiologists, if the licensee holding an expedited license was not required by the licensee's original jurisdiction outside of New Mexico to pass a nationally recognized standard examination in audiology, the licensee shall be required to pass the examination prior to renewing the license.

C. Upon renewal, the board shall issue a regular license to a licensee holding an expedited license issued pursuant to these rules.
[16.26.10.12 NMAC – N, 01/08/2023]

History of 16.26.10 NMAC:
16.26.10 NMAC – Emergency Licensure, filed 11/9/2006 was repealed and replaced with 16.26.10 NMAC – Expedited Licensure, effective 01/08/2023.

REGULATION AND LICENSING DEPARTMENT
SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID DISPENSING PRACTICES BOARD

This is an amendement to 16.26.1 NMAC, Section 7, effective 1/8/2023

16.26.1.7 DEFINITIONS:

A. "AAA" refers to the American academy of audiology, a national professional association of audiologists concerned with professional qualifications, standards of practice, ethics, scientific progress and continuing education.

B. "ABA" refers to the American board of audiology, which offers board certification in the discipline of audiology and is affiliated with the American academy of audiology.

C. "Act" means the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act (Sections 61-14B-1 to 61-14B-25 NMSA 1978) as it may be amended.

D. "Apprentice" means a person working towards full licensure in speech-language pathology and who meets the requirements for licensure as an apprentice in speech and language pursuant to the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act.

E. "ASHA" refers to the American speech-language and hearing association, a national professional association of speech-language pathologists and audiologists recognized by the secretary of the United States (U.S.) department of education for the accrediting of university graduate degree programs in audiology and speech-language pathology. ASHA also maintains a professional membership of speech-language pathologists and audiologists concerned with professional qualifications, standards of practice, ethics, scientific progress and continuing education.

F. "Audiologist" means a person who engages in the practice of audiology, who may or may not dispense hearing aids, and who meets the qualifications set forth in the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act.

G. "Certified" means a notarized statement of authenticity of a true copy.

H. "Client/patient" means an individual receiving services from an Audiologist, Speech Language Pathologist or Hearing Aid Dispenser

I. "CFY plan" (clinical fellowship year plan) means a written plan submitted to the board outlining the duration of the CFY (up to a maximum of three years), the CFY plan must designate a CFY supervisor and outline the amount and type of supervision.

J. "Direct supervision" means on-site, in-view observation and guidance while a clinical activity is performed by the supervisee. This can include viewing and communicating with the supervisee via telecommunication technology so long as the supervisor or qualified sponsor is able to provide ongoing immediate feedback. Direct supervision does not include reviewing a taped session at a later time.

K. "Electronic signature" means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

L. "Expedited license" means a provisional license that confers the same rights, privileges and responsibilities as a regular license issued by the board.

[~~L.~~] **M. "Facilitator"** means a person at the client site who facilitates telehealth service delivery at the direction of the audiologist, speech-language pathologist or hearing aid dispenser. For purposes of fulfilling their role, as defined, an individual may serve as a facilitator, at the direction of the audiologist or speech language pathologist, without becoming licensed.

[~~M.~~] **N. "IHS"** refers to the *international hearing society*, an international membership association that represents hearing healthcare professionals engaged in the practice of testing human hearing and selecting, fitting and dispensing hearing instruments and counseling patients. IHS conducts programs in competency accreditation, education and training and encourages specialty-level certification for its members.

[~~N.~~] **O. "ILE"** refers to the *international licensing examination for hearing healthcare professionals* administered by IHS on behalf of the board for the purposes of licensing hearing aid dispensers.

[~~O.~~] **P. "Indirect supervision"** means supervision that does not require the SLP to be physically present or available via telecommunication in real time while

the supervisee is providing services. Indirect supervisory activities may include demonstration tapes, record review, review and evaluation of audio or videotaped sessions, or supervisory conferences that may be conducted by telephone or live, secure webcam via the internet.

[~~P.~~] **Q. "Jurisprudence examination"** means the evaluation of knowledge of the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act and these regulations, given as a requirement for licensure to all applicants.

[~~Q.~~] **R. "License"** means a document identifying a legal privilege and authorization to practice within one of the categories established by the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act. A license under this act is not transferable.

[~~R.~~] **S. "Licensing year"** means the period from January 31, of any year through January 30 of the next year; initial, renewed and reinstated licenses may be issued at any time set herein but shall expire on January 30 of the following year except as otherwise provided in these rules.

[~~S.~~] **T. "NBC-HIS"** means national board for certification in hearing instruments sciences.

[~~T.~~] **U. "Qualified Sponsor"** means a person who currently holds an audiology or hearing aid dispenser license in good standing with the board and who voluntarily accepts the responsibility of supervising, training or overseeing an individual interested in obtaining an endorsement or license to fit and dispense hearing aids.

[~~**U. "Reciprocity"** means the ability of a qualified applicant from another state to obtain a license in the state of New Mexico.~~]

V. "Referral" means the process of directing or redirecting a customer or patient to a specialist, hearing aid dispenser, therapist or clinician for services or diagnosis.

W. "Site" means the client/patient location for receiving telehealth services.

X. "Stored clinical data" means video clips, sound/audio files, photo images, electronic records, and written records that may be available for transmission via telehealth communications.

Y. "Student" means any person who is a full or part time student enrolled in an accredited college or university program in speech-language pathology, audiology or communication disorders.

Z. "Telecommunication technology" includes but is not limited to a dedicated video system, computer or other similar device linked via hardwire or internet connection, equipment, connectivity, software, hardware and network-compatible devices.

AA. "Telehealth" means the use of telecommunications and information technologies for the exchange of information from one site to another for the provision of Audiology, Speech-Language Pathology or Hearing Aid Dispensing services to an individual from a provider through hardwire or internet connection**.**

BB. "Telepractice" means the practice of telehealth.

CC. "Temporary paraprofessional license" means a license issued to a person working towards full licensure as a speech-language pathologist and who provides adjunct speech-language pathology services under the supervision of a speech-language pathologist who is licensed under this act.

DD. "Temporary trainee permit" means a permit issued by the board to a person authorized to fit and dispense hearing aids only under the supervision of a qualified sponsor as defined by these regulations. Temporary trainee permits will be issued for a one-year period and are non-renewable.

[12/21/71; 2/5/80; 8/1/81; 8/4/81; 3/18/82; 10/21/91; 11/09/96; 11/7/98; 11/27/99; 16.26.1.7 NMAC - Rn & A, 16 NMAC 26.1.7, 2/3/06; A, 1/29/15; A, 4/6/16; A, 2/14/2017; A, 01/08/2023]

REGULATION AND LICENSING DEPARTMENT

SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY AND HEARING AID DISPENSING PRACTICES BOARD

This is an amendement to 16.26.2 NMAC, Sections 8, 10, 11, 12 and 14, effective 1/8/2023

16.26.2.8 LICENSING REQUIRED TO PRACTICE:

A. Section 61-14B-7 NMSA 1978 of the act provides that no person shall practice or hold him or herself out as being able to practice speech-language pathology, audiology, hearing aid dispensing in the state of New Mexico unless he or she is licensed in accordance with the provisions of this act.

B. All individuals licensed under this act must display their license in their primary location at their place of employment.

C. Separate licenses shall be granted in speech-language pathology, audiology, and hearing aid dispensing. An applicant may be granted a dual license for speech-language pathology and audiology upon successful completion of requirements for both of these licenses. A hearing aid dispensing license does not indicate that the person holding the license is an audiologist.

[~~**D.** The board shall have 30 days from the receipt of a complete application to process and approve an application.~~

~~**E.** The board shall issue a license by reciprocity to an applicant from another state who holds a current license in good standing with no pending disciplinary action, provided the requirements for the current license held meet or exceed requirements for licensure for Speech Language Pathology, Audiology, or Hearing Aid Dispensing in the state of New Mexico.~~]

[16.26.2.8 NMAC - Rp, 16 NMAC 26.2.8, 2/3/2006; A, 2/14/2017; A, 01/08/2023]

16.26.2.10 REQUIREMENTS FOR ALL EXAMINATION APPLICANTS: An applicant for a license by examination to practice under the Speech-Language Pathology, Audiology, and Hearing Aid Dispensing Practices Act must submit the following:

A. a complete and signed application on a form prescribed by the board;

B. a check or money order payable to the board for the applicable fee(s) outlined in 16.26.6.8 NMAC;

C. documentation relevant to the license sought under 16.26.2 NMAC;

D. certification that the applicant is not guilty of any activities listed in Section 61-14B-21 NMSA 1978; and

E. The certification that the applicant has not been [~~covicted~~] convicted of felonies listed in Subsection F of 16.26.8 NMAC

[16.26.2.10 NMAC - Rp, 16 NMAC 26.3.8, 2/3/2006; A, 11/29/2008; A, 4/6/2016; A, 2/14/2017; A, 2/10/2022; A, 01/08/2023]

16.26.2.11 QUALIFICATIONS AND APPLICATION FOR LICENSURE AS A SPEECH-LANGUAGE PATHOLOGIST BY EXAMINATION: An application for licensure as a speech-language pathologist by examination must be accompanied by the following documents:

A. official transcripts verifying at least a master's degree in speech-language pathology, speech-language and hearing science, communication disorders or equivalent degree regardless of degree name; or

B. a certification bearing an official seal and attesting to completion of degree requirements from the registrar, mailed directly to the board from the conferring institution; and

C. proof of having earned a certificate in speech-language pathology from a board recognized national speech-language association or proof of completion of the clinical fellowship year or equivalent; and

D. proof of having passed a nationally recognized standard examination in speech-language pathology;

E. proof of having passed the jurisprudence examination with a grade of no less than seventy percent[~~; and~~]

[~~**F.** if currently or previously licensed in another state a verification of licensure must be sent directly to the board by the issuing jurisdiction.~~]

[16.26.2.11 NMAC - Rp, 16 NMAC 26.2.11, 2/3/2006; A, 11/29/2008; A, 4/6/2016; A, 1/4/2020; A, 01/08/2023]

16.26.2.12 QUALIFICATIONS AND APPLICATION FOR LICENSURE AS AN AUDIOLOGIST BY EXAMINATION: Application for licensure by examination as [~~a~~] an audiologist must be accompanied by the following documents:

A. official transcripts or certification from the registrar verifying the following:

(1) a master's degree in audiology, communication disorders or equivalent degree in audiology or communication disorders awarded prior to January 1, 2007; or

(2) a doctoral degree in audiology or equivalent degree regardless of degree name.

B. proof of having earned certification in audiology from the American speech-language and hearing association (ASHA) or the American board of audiology (ABA);

C. proof of having passed a nationally recognized standard examination in audiology;

D. proof of having passed the jurisprudence examination with a grade of no less than seventy percent;

E. if the applicant was awarded a master's degree in audiology or communication disorders or equivalent degree in audiology or communication disorders prior to January 1, 2007, the applicant must also provide proof of at least six months' experience in the dispensing of hearing aids or other evidence as determined by the board in either a graduate training program or in a work training experience;

[~~**F.** if currently or previously licensed in another state, a verification of the applicant's licensure must be sent directly to the board by the issuing jurisdiction.~~]

[16.26.2.12 NMAC - Rp, 16 NMAC 26.3.9, 2/3/2006; A, 11/29/2008; A, 6/7/2010; A, 1/15/2015; A, 4/6/2016; A, 1/8/2023]

16.26.2.14 QUALIFICATIONS AND APPLICATION FOR LICENSURE FOR A HEARING AID DISPENSER BY EXAMINATION: [~~**A.**~~] Application for licensure by examination as a hearing aid dispenser must be accompanied by documentation of the following:

[~~**(1)**~~] **A.** proof that the applicant is 18 years of age or older;

[~~**(2)**~~] **B.** proof that the applicant has a high school education or the equivalent;

[~~**(3)**~~] **C.** proof that the applicant has a business location in New Mexico;

[~~**(4)**~~] **D.** a notarized letter from the qualified sponsor verifying completion of all training requirements as outlined for the temporary hearing aid dispensing trainee permit;

[~~**(5)**~~] **E.** proof of having passed the current IHS administered ILE within the previous 24 months;

[~~**(6)**~~] **F.** passing the board administered practical exam with a score of no less than seventy percent;

[~~**(7)**~~] **G.** proof of having passed the jurisprudence examination with an overall score of no less than seventy percent; and

[~~**(8)**~~] **H.** have no disciplinary actions taken against any professional license they hold in any state or jurisdiction.

[~~**B.** An applicant who is licensed as a hearing aid dispenser or~~

~~hearing aid specialist in another state or jurisdiction may be issued a license as a hearing aid dispenser in New Mexico upon the board's acceptance of the following:~~

~~(1) proof that the applicant is 18 years of age or older;~~

~~(2) proof that the applicant has a high school education or the equivalent;~~

~~(3) proof that the applicant has a business location in New Mexico;~~

~~(4) the requirements for licensure in the issuing state or jurisdiction meet or exceed the standards for New Mexico; and~~

~~(5) the applicant has no disciplinary actions taken or pending against any professional license they hold in any state or jurisdiction~~]

[16.26.2.14 NMAC - Rp, 16 NMAC 26.3.11, 2/3/2006; A, 6/7/2010; A, 1/15/2015; A, 4/6/2016; A, 2/14/2017; A & Rn, 1/8/2023]

SUPERINTENDENT OF INSURANCE, OFFICE OF

TITLE 13 INSURANCE
CHAPTER 22 AUTOMOBILE THEFT PREVENTION AUTHORITY
PART 2 BOARD AND GRANT ADMINISTRATION

13.22.2.1 ISSUING AGENCY: Office of Superintendent of Insurance ("OSI").
[13.22.2.1 NMAC – N, 01/01/2023]

13.22.2.2 SCOPE: This rule applies to the activities of the New Mexico Automobile Theft Prevention Authority ("NMATPA") board and to its review, approval and administration of grants pursuant to Section 59A-16C-17 NMSA 1978.
[13.22.2.2 NMAC – N, 01/01/2023]

13.22.2.3 STATUTORY AUTHORITY: Sections 59A-16C-5, 59A-16C-16 and 59A-16C-17 NMSA 1978.
[13.22.2.3 NMAC – N, 01/01/2023]

13.22.2.4 DURATION: Permanent.
[13.22.2.4 NMAC – N, 01/01/2023]

13.22.2.5 EFFECTIVE DATE: January 1, 2023, unless a later date is cited at the end of a section.
[13.22.2.5 NMAC – N, 01/01/2023]

13.22.2.6 OBJECTIVE: This rule establishes definitions and procedures for the conduct of business by the NMATPA board and for the review, approval and administration of grants made by that board pursuant to Section 59A-16C-17 NMSA 1978.
[13.22.2.6 NMAC – N, 01/01/2023]

13.22.2.7 DEFINITIONS:

A. "Automobile theft prevention authority" or "ATPA" has the meaning provided in Section 59A-16C-17 NMSA 1978.

B. "Automobile" means a motor vehicle or vehicle.

C. "Board of directors" or "board" means the board of directors of the automobile theft prevention authority that is appointed in accordance with Subsection A of Section 59A-16C-17 NMSA 1978.

D. "Executive director" means a supervising prosecuting attorney of the OSI, as designated by the superintendent of insurance.

E. "Grant announcement" means an announcement by the board or executive director that grant funding is available. The announcement shall include a reference to all required application materials and the deadline for submission of grant applications.

F. "Grant award" means a final decision of the NMATPA board to award a grant to a qualified applicant.

G. "Grant award contract" means a written contract that arises as the direct result of a grant award and sets out the respective duties and obligations of NMATPA and a grant awardee. An attorney designated by the superintendent of insurance shall review every grant award contract before the contract is signed. The reviewing attorney shall not be the executive director of NMATPA.

H. "Grant awardee" means a qualified applicant whose grant application has been approved by the board and to whom notification of a grant award has been sent in accordance with this rule.

I. "Grant cycle" means the period of time between the grant announcement and a grant award.

J. "Grant managers guidance manual" or "GMG" means the most current publicly available version of the guidance manual approved by the board for providing information on grant application requirements and processes. The ATPA board shall update the GMG annually.

K. "Grant recipient" means a grant awardee.

L. "Motor vehicle" has the meaning provided in the Motor Vehicle Code, Chapter 66, Article 1 NMSA 1978.

M. "New Mexico automobile theft prevention authority" or "NMATPA" means the automobile theft prevention authority established for the state of New Mexico by Section 59A-16C-17 NMSA 1978.

N. "NMATPA administration" means the OSI staff responsible for the day-to-day operations and support of the board.

O. "Qualified applicant" means a state, local or regional law enforcement agency or task force that demonstrates that its proposed program satisfies grant requirements and addresses a significant aspect of automobile theft prevention.

P. "Vehicle" has the meaning provided in the Motor Vehicle Code, Chapter 66, Article 1 NMSA 1978.
[13.22.2.7 NMAC – N, 01/01/2023]

13.22.2.8 BOARD OF DIRECTORS:

A. Board responsibilities. The main responsibility of the board is to administer and manage grants made in accordance with Section 59A-16C-17 NMSA 1978. The duties of the board include, without limitation:

(1) reviewing grant applications;

(2) awarding grants consistent with the criteria set forth in this rule;

(3) reviewing grant reports and compliance by grantees; reporting on the work of the board as required by law; and

(4) other duties consistent with Section 59A-16C-17 NMSA 1978, as may be from time to time determined by a majority vote of the board. The executive director may request that the board undertake additional duties on a temporary basis in order to facilitate the orderly implementation of this rule.

B. Board meetings. All meetings of the board shall be held in compliance with the Open Meetings Act, Chapter 10, Article 15 NMSA 1978. The board shall meet at least once every three months, except that the board may, at the call of the chair or at the request of the executive director, or by majority vote, decide to meet more frequently. All meetings of the board shall be recorded and transcribed, and NMATPA will post the transcriptions on the official OSI website. A board meeting may be held in person or virtually. A quorum of the board shall consist of five members of the board and may be achieved through participation in a virtual meeting.

C. Board actions. A quorum of the board shall review the grant applications. A majority of the board shall approve the grant awards. The board may adopt additional policies and procedures governing its processes.

[13.22.2.8 NMAC – N, 01/01/2023]

13.22.2.9 EXECUTIVE DIRECTOR: The executive director of the NMATPA shall serve ex officio in an official capacity as a supervising prosecuting attorney of OSI.

A. Duties of executive director. The executive director shall have the following duties:

(1) directing the NMATPA administration, as defined in Section 7 of this rule;

(2) preparing the agenda for board meetings, in consultation with the members of the board;

(3) posting meeting agendas as required by the Open Meetings Act; and

(4) other duties not inconsistent with the executive director's general scope of work as may from time to time be conferred by the board.

B. Authority of executive director. The executive director shall have the following authority:

(1) calling a meeting of the board;

(2) signing grant award contracts, as defined in Section 7 of this rule, on behalf of the NMATPA; and

(3) such other authority as may be necessary to carry out the duties of the executive director.

[13.22.2.9 NMAC – N, 01/01/2023]

13.22.2.10 GRANT MANAGERS GUIDANCE MANUAL ("GMG"): The board shall annually review, approve and adopt the NMATPA GMG during one or more board meetings. As soon as practicable after the board's annual review, approval and adoption of the GMG, the executive director will publish the GMG by posting a copy of the GMG on the official OSI website.

A. GMG content. The board shall use its best judgment to determine the content of the NMATPA GMG with the following goals in mind:

(1) Clarity of purpose;

(2) Completeness of content;

(3) Ease of comprehension; and

(4) Ease of use.

B. GMG designation. The board may designate an existing GMG for continued use by clearly designating an existing GMG as the most current version. The board may adopt one or more GMGs from other states and jurisdictions that have adopted a GMG, consistent with applicable copyrights and authorship laws. The board may adopt a complete version of the GMG, an abridged version, or both in order to facilitate outreach to intended audiences as the board may deem appropriate. If more than one version is adopted, then each version shall be clearly marked as to its intended use.

C. Current version of GMG. The board shall designate which version of a complete GMG is the most current version and shall post only that version on the official OSI website. The most current GMG shall control for purposes of reviewing, approving and awarding grants; reviewing and reporting compliance with grants; and in case of a discrepancy between versions.

D. Conflict between GMG and Rule. In the event of a conflict between the GMG and this rule, this rule shall control. All editions of the GMG adopted by the board shall state that this rule takes precedence over the GMG in the event of conflict.

[13.22.2.10 NMAC – N, 01/01/2023]

13.22.2.11 GRANT APPLICATIONS – SUBMISSION AND CONTENT:

A. Application submission period. The board will announce annually in writing the availability of grant funding and the start of the application submission period. OSI will publish the notice on the official OSI website and distribute the notice via email to all entities that have signed up for OSI's newsletter email listserv.

B. Application format and required content. An application shall be in the form required by the grant announcement, consistent with the requirements set forth in Section

59A-16C-17 NMSA 1978, this rule and the NMATPA GMG. Grant application and approval forms shall be the most current version adopted by the board.

(1) A grant application shall describe, at minimum, the specific type of automobile theft prevention, enforcement, specialized training, prosecution or first-time offender rehabilitation program proposed.

(2) A grant application shall include or address all required information, forms, and instructions provided in the NMATPA GMG.

C. Method and delivery of application submission. Applications shall be filed with the board electronically as directed in the grant application, notice, or instructions.

D. Scope of grants. Possible funding categories for NMATPA grants include, without limitation:

(1) equipment for law enforcement;

(2) law enforcement services, including overtime pay;

(3) public awareness campaigns; and

(4) other goods or services that meet the objectives of Chapter 59A, Article 16C NMSA 1978.

[13.22.2.11 NMAC – N, 01/01/2023]

13.22.2.12 GRANT AWARDS: The NMATPA board shall award grants on a competitive basis, subject to available funding, and in accordance with the priorities described in this rule. There shall be no automatic entitlement to a grant, and the board shall not be required to award a grant if no application satisfies the criteria set forth in the applicable grant announcement.

A. Use of the NMATPA GMG. The board shall review applications consistent with Section 59A-16C-17 NMSA 1978, these rules, and the guidance set out in the most current version of the NMATPA GMG.

B. Multi-jurisdictional priority. The board shall give priority to those grant applications representing multi-jurisdictional programs. Applicants representing multiple jurisdictions may submit joint applications.

C. Minimum description required. An application shall, at a minimum, provide a thorough description of the type of automobile theft prevention, enforcement, specialized training, prosecution, or first-time offender rehabilitation program proposed. The minimum description shall include staffing, objectives, measurable goals and costs.

D. Applicable review guidelines. The board shall review each application to determine whether the submitting entity meets the definition of a qualified applicant. The board will then further review the applications received pursuant to the following guidelines:

(1) Whether the application identifies an automobile theft problem clearly, is measurable, and is supported by relevant statistical evidence;

(2) whether the application minimizes duplicative or overlapping existing programs;

(3) whether the application provides a design wherein activities and goals are realistic and attainable;

(4) whether the application displays innovation in its concept, design, or operation. A project is considered innovative if it provides a new and different strategy or approach that prevents, deters, intervenes or reduces the occurrence of automobile theft-related activity;

(5) whether the application demonstrates a realistic cost structure as compared to its goals (cost compared to benefit);

(6) whether the application includes a proposed evaluation design supported by relevant data to measure the effectiveness of the project and a plan for completing said evaluation consistent with applicable grant reporting requirements; and

(7) whether the application was submitted timely and in the prescribed format in accordance with the applicable grant announcement.

E. Equitable review. The board will apply relevant statutes, this rule and the NMATPA GMG to ensure equitable review of grant applications received from law enforcement agencies and other qualified applicants.

F. Geographic distribution. The board will approve grants in a variety of geographic areas of the state to the extent that it is practicable to do so.

[13.22.2.12 NMAC – N, 01/01/2023]

13.22.2.13 GRANT AWARDS AND NOTIFICATION: Subject to available funds, the board will approve grants in accordance with Section 59A-16C-17 NMSA 1978, this rule and the guidance set forth in the most current version of the NMATPA GMG.

A. Approval criteria. In approving grants, the board shall consider the following criteria:

(1) available funds;

(2) existing activities or programs addressing the same or substantially similar automobile theft problem;

(3) statistical analyses of automobile theft problems in the identified project area;

(4) cooperation and coordination with other agencies and projects to address automobile theft problems;

(5) proposed plan for automobile theft crime prevention, enforcement, prosecution and training;

(6) number of personnel involved in the proposed project; and

(7) the applicant's experience, qualifications and past performance demonstrating ability to operate a proposed project successfully.

B. Grant awards. A quorum of the board shall review grant applications. A majority vote

of the board shall be required for approval of a grant application.

C. Notification. Within 10 business days of a grant award, the executive director will notify each applicant in the current grant cycle of the board's decision to approve or deny an application.

(1) The board may condition a grant award on an applicant's satisfaction of reasonable requirements in addition to those identified in the grant announcement and the NMATPA GMG.

(2) The board shall not require as a condition of receipt of a grant that an agency, political subdivision, or other qualified applicant provide any additional monies to operate a recommended program.

(3) An applicant may accept or decline a grant award consistent with the schedule set forth in the NMATPA GMG.

[13.22.2.13 NMAC – N, 01/01/2023]

13.22.2.14 GRANT EVALUATION PROCEDURES: So that the board can evaluate program success and compliance, all grant recipients must submit quarterly program and financial reports to the board following grant application approval and fund disbursement.

A. Reporting forms provided. The board will provide grant recipients with forms necessary to submit required quarterly financial and program progress/achievement reports.

B. Board review criteria. Board review of quarterly reports submitted by the grant recipients shall be consistent with identified goals and objectives of the NMATPA.

C. Program monitoring. The board will monitor program implementation, financial administration, and achievement of declared program objectives consistent with Section 59A-16C-17 NMSA 1978, this rule and the NMATPA GMG as applicable.

D. Board feedback. The board will provide feedback to grant recipients submitted or failing to submit required quarterly reports, or as is appropriate and consistent with statute, the goals and objectives of the NMATPA, this rule and the NMATPA GMG.

E. Failure to perform. A program that is failing to perform will be given written notice at least 30 days prior to implementation of any remedies identified in this subsection and may request board review of the contemplated action. In the event that a grant recipient fails to perform or complete required quarterly financial and program progress and achievement reports, the board may:

(1) elect to apply a program improvement plan to the recipient to rehabilitate performance;

(2) recommend to the superintendent or the superintendent's designee for revocation or suspension of recipient's grant agreement; or

(3) recommend to the superintendent or the superintendent's designee that reimbursement for expenses be denied.

F. Future consideration: Failure to perform or rehabilitate may affect future consideration of applications submitted to the board by the same applicant.

[13.22.2.14 NMAC – N, 01/01/2023]

History of 13.22.2 NMAC: [RESERVED]

SUPERINTENDENT OF INSURANCE, OFFICE OF

This is an amendment to 13.10.31 NMAC, Section 12, effective 01/01/2023.

13.10.31.12 [~~RESERVED~~] EVALUATION OF PRIOR AUTHORIZATION POLICY AND PROVIDER PERFORMANCE:

A. Applicability. This section of the rule shall only apply to fully-insured commercial coverages regulated by the superintendent.

B. Review of covered benefits that require prior authorizations. Annually, beginning in 2023, a carrier shall review its prior authorization requirements for all covered benefits, except for inpatient admissions to acute-care hospitals, including transfers, in order to assess the continued utility of each requirement.

(1) At a minimum, a carrier's assessment shall consider the following elements:

(a) the approval rate for each covered benefit for which a prior authorization was required;

(b) whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered benefit protects patient safety or generates better health outcomes, or both;

(c) whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered benefit prevents the need for higher cost services;

(d) whether based on demonstrable evidence, including claims and clinical data, the prior authorization requirement of each covered benefit has deterred any reasonable suspicion of insurance fraud, waste, or abuse;

(e) whether, based on demonstrable evidence, including claims, clinical and operational data, and considering both the providers' and the carrier's experience, the costs and other administrative burdens associated with the prior authorization requirement for a covered benefit outweigh the demonstrated benefits of the requirement; and

(f) whether the prior authorization requirement for a covered benefit, based on demonstrable evidence including provider and member grievances, appeals and complaints, and claims and clinical data, contributed to unreasonable or

unnecessary delays in treatment or adverse health outcomes for a covered person.

(2) A carrier shall conduct and complete the review by the end of the second quarter of each calendar year, beginning in 2023, and shall evaluate the prior authorizations issued during the prior calendar year.

(3) A carrier shall identify those covered benefits, with the exception of inpatient admissions to acute care hospitals, for which ninety percent of the prior authorization requests for that benefit are approved.

(4) A carrier shall prepare a report of its annual assessment that, at a minimum, contains its findings based on the elements listed above, and identifies any change in prior authorization requirements.

(a) The report shall be submitted to the superintendent no later than October 31, 2023 and no later than September 30th of every year thereafter, beginning in 2024.

(b) The report shall be submitted in the form and manner proscribed by annual guidance issued pursuant to Subsection G of this Section.

(5) A carrier that enters the market in 2023 or later shall conduct its first prior authorization evaluation during its second full calendar year in the market.

(6) If no protection of patient safety or no better health outcomes related to prior authorization of a covered benefit can be shown by the carrier, the prior authorization requirement must be eliminated for 12 months or until the carrier is able to demonstrate additional evidence to support its position.

C. Assessment of prior authorization request outcomes. Beginning in the first quarter of 2023, a carrier shall annually evaluate its network providers' patterns of adherence to the carrier's prior authorization criteria and policies in the preceding calendar year. For the first year, prior authorization requests for admissions to general acute care hospitals, psychiatric hospitals, and rehabilitation hospitals, and durable medical equipment, including oxygen and disposable medical supplies, shall be excluded from this evaluation. The superintendent may include these services in subsequent years pursuant to the annual guidance issued in accordance with Subsection G of this Section.

(1) A carrier shall identify providers who are the most frequent submitters of prior authorizations, and who have a consistent pattern of adherence to prior authorization requirements and criteria as evidenced by prior authorization approval rates of ninety percent or greater (a "high compliance provider").

(2) A carrier shall select no less than thirty percent of its high compliance providers and shall:

(a) enter into an agreement with each selected high-compliance provider on an alternative to the standard requirement to submit a prior authorization request for a discreet service or set of services that otherwise require one (an alternate arrangement); and

(b) the agreement with each provider shall clearly describe the terms of the alternate arrangement, including under what conditions the agreement can be terminated by a carrier or a provider. The agreement shall include how the provider's ordering and prescribing performance during the course of the alternative arrangement will be monitored and evaluated, how results will be communicated, and how the agreement can be extended beyond the base period of the agreement. At a minimum, the agreement will be effective for 12 months.

(3) The high compliance providers selected for alternate arrangements shall be representative of the various eligible types of providers, including specialists, that participate in a carrier's network, and the spectrum of covered benefits.

(4) The first year's alternative arrangements shall go into effect on January 1, 2024, and all subsequent years' agreements shall go into effect on the first day of the year.

(5) After the first year, a carrier shall increase the number of high compliance providers with which it enters into alternate arrangements by at least fifty percent of providers who had alternative arrangements in the first year. If a carrier is not able to increase the number of providers with alternate arrangements by at least fifty percent compared to the prior year, the carrier shall request an exception according to guidance issued by the superintendent. The exception request will be subject to the approval of the superintendent.

(6) After the second year, a carrier shall comply with specific performance requirements identified in guidance issued pursuant to Subsection G of this section.

(7) A carrier may elect to remove a prior authorization requirement at any time, in accordance with Paragraph (3) of Subsection C of Section 13.10.31.8 NMAC above.

D. Annual report. A carrier shall, by September 30th of each year, submit a report to the superintendent that:

(1) describes the evaluation process and criteria used to identify high compliance providers;

(2) lists the providers identified, the providers with whom an alternate arrangement was made, and the providers with whom negotiations are ongoing; and

(3) describes, in general, the terms of the alternate arrangements entered into, including the effective dates of the agreement, the services involved, performance evaluation, and communication provisions; and

(4) describes experiences making these alternate arrangements, the results of the alternate arrangements when known, lessons learned, and recommendations to the superintendent.

E. New carriers. A carrier that enters the market in 2023 or later shall conduct its first prior authorization evaluation in its second full calendar year in the market unless the carrier has not met a threshold enrollment of more than 500 members in which case the carrier shall file the first year after it meets that enrollment threshold

F. Data confidentiality and use. Information reported to the superintendent concerning a specific, identifiable, provider shall be deemed confidential pursuant to Subsection B of Section 59A-2-12 NMSA 1978. The superintendent may publish and use any other reported information for any regulatory purpose, including development and promulgation of rules to specify minimum prior authorization incentive and corrective action programs.

G. Guidance. The superintendent shall annually publish guidance for carriers for the upcoming plan year. This guidance shall include, at minimum, procedural reporting requirements, and any specific performance requirements.

[13.10.31.12 NMAC - N, 01/01/2022; A, 01/01/2023]

SUPERINTENDENT OF INSURANCE, OFFICE OF

This is an amendment to 13.10.35 NMAC, Sections 2, 3, 7, 8, 9, 10, 11, and 13, effective 01/01/2024.

13.10.35.2 SCOPE: This rule applies to every carrier who offers or sells any individual or group dental or vision insurance plan ("plan") separately from a health benefits plan, whether on or off the exchange. This rule does not apply to any pediatric dental or vision plan, or to any prepaid dental plan. Subject to the foregoing, this rule applies to a group dental or vision plan offered or sold to a New Mexico resident under a master policy delivered outside of this state.

[13.10.35.2 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.3 STATUTORY AUTHORITY: Sections 59A-2-9, 59A-23F-7, and 59A-23G-1 et seq. NMSA 1978.

[13.10.35.3 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.7 DEFINITIONS: For definitions of terms contained in this rule, refer to 13.10.29 NMAC, unless otherwise noted below.

A. "Domestic co-insured" means a spouse or domestic partner insured under the same plan or certificate.

[~~**B. "Preferred provider"** means a dental or vision care provider, or group of providers, who contracts with a dental or vision insurance carrier to provide dental or vision services to a covered person.~~]

B. "Earned premiums" for a reporting year means the premium received up to the loss ratio measurement date that provided coverage during that reporting year.

C. "Incurred claims" for a reporting year means the claims for which services were provided in the reporting year. This includes such claims that were paid in the reporting year plus unpaid claims reserves for such reporting year.

D. "Loss ratio" means the incurred claims divided by earned premiums, calculated pursuant to Subsection D of 13.10.35.9 NMAC.

E. "Loss ratio measurement date" means the date as of which the incurred claims and earned premiums for each reporting year are determined for the reporting required in Subsection M of 13.10.35.9 NMAC of this rule.

F. "Preferred provider" means a dental or vision care provider, or group of providers, who contracts with a dental or vision insurance carrier to provide dental or vision services to a covered person.

G. "Reporting year" means a calendar year during which group or individual dental coverage is provided by a policy, contract or certificate covering dental services.

H. "Schedule of benefits" means any form that is part of an insurance policy filed with and approved by the superintendent that contains any of the following information: coverage levels, cost sharing features, covered services, benefit maximums and exclusions.

I. "Unpaid claim reserves" for a reporting year means reserves and liabilities established as of the applicable loss ratio reporting year but were paid after the reporting year.

[13.10.35.7 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.8 GENERAL PROHIBITED POLICY PROVISIONS:

A. Probationary and waiting periods. Except as otherwise expressly allowed under Sections 10 and 11 of this rule, a plan shall not include any probationary or waiting period during which no coverage is provided for a covered benefit, except an eligibility waiting period during which no premium is paid.

B. Riders and other supplements. Any rider, amendment, endorsement or other supplement shall explicitly state which terms of coverage the carrier has amended or supplemented from the original plan.

C. Exclusions. A plan that includes [~~a preexisting condition exclusion~~] any exclusions shall comply with these requirements:

(1) each plan application shall include a prominent notice that the plan includes a preexisting exclusion, and display either the full text of the exclusion or directions as to how to obtain a copy of that text.

(2) the carrier shall not enforce a preexisting condition exclusion if an enrollee renews coverage under a plan offered by the same carrier.

(3) a plan application shall not request family member health information unless the family member is also seeking coverage under the plan; and

(4) a plan may exclude benefits for the replacement of a tooth that the covered person lost prior to the covered person's plan effective date unless the covered person had coverage from a prior carrier.

D. Evidence of coverage. Upon request, a carrier shall provide a current or former enrollee evidence of that person's current or former coverage under a plan.

E. Marketing of blanket or group coverages. A carrier shall not sell any blanket coverage to a group that is not described in Section 59A-23-2 NMSA 1978, or group coverage that is not identified or described in Section 59A-23-3 NMSA 1978.

F. Arbitration provisions. A plan shall not require a covered person to submit a dispute to mediation or arbitration.

G. Plan governance. A covered person's rights under any plan shall be governed by the terms of the plan approved by the superintendent, and by applicable state and federal law.

H. Discrimination. No plan shall discriminate in eligibility for coverage or benefits on the basis of sex, sexual orientation, gender, race, religion, or national origin.

I. Conversion privileges. A carrier shall not offer a conversion plan that is not approved by the superintendent.

J. Gag rule. A plan shall not include, and a carrier shall not otherwise impose, a gag rule or practice that prohibits a dental or vision service provider from discussing a treatment option with a covered person.

[13.10.35.8 NMAC - N, 01/01/2022, A, 01/01/2024]

13.10.35.9 GENERAL STANDARDS FOR POLICIES AND BENEFITS:

A. For individual plans. The following general standards apply to individual plans.

(1) An individual plan shall have a minimum term of 12 months.

(2) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual plan shall not provide for termination of coverage of the domestic co-insured solely because of the occurrence of an event specified for termination of coverage of the covered person, other than nonpayment of premium. In addition, the plan shall provide that in the event of the covered person's death, the domestic co-insured of the covered person, if covered under the plan, shall become a covered person with the issuance of a new policy and completed agreement.

(3) An individual plan shall protect consumer rights as follows:

(a) The terms "noncancellable" or "noncancellable and guaranteed renewable" may only be used in an individual dental or vision plan if the covered person has the right to continue the coverage by timely paying premiums, until the age of 65 or until eligibility for Medicare, whichever is later, during which time the carrier has no unilateral right to change any provision of the plan.

(b) The term "guaranteed renewable" may only be used in a plan where the covered person has the right to continue in force, by timely paying premiums, until the age of 65 or until eligibility for Medicare, whichever is later, during which period the carrier has no unilateral right to change any provision of the plan, other than changes in premium rates by classes.

(c) A plan shall not terminate the coverage of a covered person except for "good cause," as follows:

(i) failure of the covered person or subscriber to pay the premiums and other applicable charges for coverage;

(ii) material failure to abide by the rules, policies or procedures of the plan;

(iii) fraud or misrepresentation affecting coverage;

(iv) policyholder request for cancellation;

(v) policy term ends; or

(vi) a reason for termination or failure to renew that the superintendent determines is not objectionable.

(4) If an individual plan covers domestic co-insureds, the age of the younger insured shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older insured upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period specified in the policy.

B. For individual and group plans. The following general standards apply to both individual and group plans.

(1) A carrier may not terminate a plan unless it provides written notice of termination to a covered person one month prior to the coverage renewal date. A notice of termination shall:

(a) be in writing and dated;

(b) state the reason(s) for termination, with specific references to the clauses of the dental or vision plan giving rise to the termination;

(c) state that a covered person's plan cannot be terminated because of health status, need for services, race, gender, or sexual orientation of covered persons under the contract. Age may only be a factor in termination of coverage as outlined in Paragraph (4) of Subsection A and Paragraph [~~(7)~~] (8) of Subsection B of this section;

(d) state that a covered person who

alleges that an enrollment has been terminated or not renewed because of the covered person's health status, need for health care services, race, gender, age or sexual orientation may file a complaint with the superintendent [~~of~~] by phone or on the [~~Office of Superintendent of Insurance~~] OSI's website; and

(e) state that in the event of termination by either the covered person or the plan, except in the case of fraud or deception, the plan shall, within 30 calendar days, return to the covered person or subscriber the pro rata portion of the money paid to the plan that corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due to the plan, provided, however, that the superintendent may approve other reasonable reimbursement practices.

(2) A plan shall include a notice prominently printed on or attached to the first page of the plan stating that the covered person shall have the right to return the plan within 30 days of its delivery, and to have the premium and any required membership fees refunded, if after examination of the plan the covered person is not satisfied for any reason, provided no claim has been paid.

(3) If a plan includes a conversion privilege, the provision shall be captioned, "Conversion Privilege." The provision shall specify who is eligible for conversion and the circumstances that govern conversion, or may state that the conversion coverage will be provided as an approved plan form used by the carrier for that purpose.

(4) If a carrier requires submission of a claim form as a condition of payment, the carrier, upon receipt of notice of a claim, shall furnish to the covered person a form to be delivered in the manner offered by the carrier that is preferred by the covered person. If the carrier does not furnish a claim form within 15 days after notice of a claim, the claimant shall be deemed to have complied with the requirement to provide proof of loss if the notice of claim contains written proof describing the claim, including the character and extent of the loss of which the claim is made. Adequate proof of loss must be in the possession of the insurance company at the time funds are disbursed in payment of claims.

(5) A grace period of at least 10 days for a monthly premium plan and at least 31 days for any plan billed less frequently shall be granted for the payment of each premium falling due after the first premium. During this grace period, the plan shall continue in force.

(6) A carrier shall not use any untrue statement or inducement not specified in a policy to solicit a prospective plan enrollee.

(a) A statement shall be deemed untrue if it does not conform to fact in any respect and would be considered significant to a person contemplating enrollment with a plan.

(b) Inducements shall meet the requirements of Subsections G and H of Section 59A-16-17 NMSA 1978.

[~~**(7)** A plan may terminate the coverage of a dependent due to limiting age for a dependent per the plan's contracted age limits. However, a plan must offer coverage to dependents, regardless of age, who are physically or mentally disabled prior to reaching the limiting age and are incapable of self-sustaining employment. Coverage for a child who is physically or mentally disabled prior to reaching the limiting age and incapable of self-sustaining employment on the date the child would otherwise age out of coverage shall continue if the child depends on the covered person for support and maintenance. The plan may require that within 31 days of the date the company receives proof of the child's incapacity, the covered person may elect to continue the plan in force with respect to the child.~~]

(7) If coverage of dependents is provided, a carrier shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday, regardless of whether the dependent is enrolled in an educational institution.

(8) A plan may terminate the coverage of a dependent due to limiting age for a dependent per the plan's contracted age limits. However, a plan must offer coverage to dependents, regardless of age, who are physically or mentally disabled prior to reaching the limiting age and are incapable of self-sustaining employment. Coverage for a child who is physically or mentally disabled prior to reaching the limiting age and incapable of self-sustaining employment on the date the child would otherwise age out of coverage shall continue if the child depends on the covered person for support and maintenance. The plan may require that within 31 days of the date the company receives proof of the child's incapacity, the covered person may elect to continue the plan in force with respect to the child.

C. For group coverage. [~~A group plan shall comply with Sections 8, 9, 11, and 12 of 13.10.5 NMAC, and Subsection D of 13.10.5.10 NMAC~~]. A group plan that offers dental or vision coverage shall comply with all sections of this rule.

D. Prior approval of forms required. A carrier shall not issue, deliver, or use a form associated with applicable dental and vision plans, unless and until such form has been filed with and approved by the superintendent.

E. Prior approval of rates required. A carrier shall not use rates or modified rates for dental and vision plans unless and until such rates are filed with and approved by the superintendent.

F. Minimum loss ratios for group and individual dental plans. Benefits dental plans shall be subject to a sixty-five percent minimum loss ratio requirement.

G. Minimum loss ratios for group and individual vision plans. Benefits under vision plans shall be subject to a fifty-five percent minimum loss ratio requirement.

H. Rate filing requirements. Each carrier providing dental or vision insurance must provide an actuarial analysis in an actuarial memorandum, certified by a qualified actuary, for each individual or group plan sold in New Mexico. Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience. A rate filing for a plan which provides both dental and vision benefits under the same policy must provide information in the actuarial memorandum and other supporting documentation to separately identify and support the premiums attributed to the dental and vision coverages. The superintendent shall post on its website requirements for filing actuarial memorandums and rates for rate filing requests. These requirements may differ for:

(1) dental and vision plans;

(2) individual, small group, and large group dental and vision plans;

(3) dental and vision plans sold on and off the health benefits exchange.

I. Calculating the loss ratio for individual and group dental and vision plans. The loss ratio is calculated as the ratio of the numerator to the denominator, as defined in Paragraphs (1) and (2) below. The loss ratio shall be calculated separately for dental and vision coverages, even if both dental and vision benefits are included in a single policy or contract.

(1) Numerator. The numerator is equal to the incurred claims for the loss ratio reporting year.

(2) Denominator. The denominator is the earned premiums for the loss ratio reporting year.

J. Rate revisions. The following requirements shall apply to rate revision requests: With respect to filing rate revisions for a previously approved form, or a group of previously approved forms combined for experience, benefits may be deemed reasonable in relation to premiums provided the revised rates meet the minimum loss ratio requirements of Subsections F or G of this rule, as applicable, and most current standards applicable to rate filings as prescribed by the superintendent, pursuant to Subsection I above based on actual experience and expected experience in the rating period,

K. Rates for new plans. The following requirements shall apply to rates for dental and vision plans not previously offered for sale in New Mexico: with respect to filing rates for a new plan, benefits may be deemed reasonable in relation to premiums provided the proposed rates meet the minimum loss ratio requirements of this rule, as applicable, and most current standards applicable to rate filings as prescribed by the superintendent, based on expected experience in the first three years.

L. Disapproval of forms and rates. The superintendent shall issue a disapproval:

(1) if the benefits provided therein are unreasonable in relation to the premium charged. For purposes of this rule, a dental or vision plan that meets the minimum loss ratio requirements will be considered to have benefits that are reasonable in relation to the premium charged;

(2) If there is misrepresentation of the benefits, advantages, conditions or terms of any plan or if the plan is characterized as more favorable to the covered person than the actual terms of the plan, such as naming coverage for services or conditions for which the primary forms of treatment are listed as exclusions;

(3) If there are false or misleading statements;

(4) If the name or title of a form is misrepresenting the true nature thereof; or

(5) If the plan contains provisions that are contrary to law, discriminatory, deceptive, unfair, impractical, unnecessary or unreasonable.

M. Disclosure and reporting compliance with minimum loss ratio requirements. By July 31st following each reporting year, carriers providing dental or vision benefit coverage must submit to the superintendent an actuarial memorandum prepared by a qualified actuary, which discloses the actual loss ratio for each plan, form or certificate subject to this rule. The annual filing shall, at a minimum, include rates, rating schedules, and supporting documentation, including ratios of incurred claims to earned premiums for each calendar year since issue. Information shall be in the form prescribed by the superintendent and shall demonstrate that each plan complies with the minimum loss ratio standards. Carriers that provide dental or vision insurance coverage that acquire a line or block of business from another carrier during a reporting year are responsible for submitting the required information and reports for the assumed business, including for that part of the reporting year that preceded the acquisition.

(1) General. Carriers shall meet the minimum loss ratio established, and in the manner calculated, under this section of the rule.

(2) Aggregation. Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience.

(3) Measurement period. Compliance with the minimum loss ratio shall be measured over the last three calendar years of experience and for each calendar year of experience utilized in the rate determination process, but never less than the last three calendar years, after the initial transition period (2024 to 2026). The initial measurement period shall be calendar year 2024; the second measurement year shall be calendar years 2024 and 2025; the third measurement period shall be calendar years 2024, 2025 and 2026. Each year thereafter, the subsequent calendar year shall be added to the rolling three-year period and the oldest calendar year shall be

removed. For example, the fourth measurement period shall be calendar years 2025, 2026, and 2027.

(4)

Frequency. Loss ratios shall be calculated annually by carriers that issue vision or dental plans specified in this rule, beginning with the 2024 reporting year.

(5) Timeline.

The evidence of compliance with the minimum loss ratio requirements shall be filed with the superintendent by July 31 of the year following the reporting year. For noncredible blocks of business, the company may request a waiver of the requirement. The request shall be made annually and must be accompanied by a letter indicating the nature of the filing, the type of plan, and the reason for the request.

(6)

Methodology. For existing plans, actual loss ratios shall be calculated using company historical claim data including an estimate for claims incurred but not reported, as appropriate.

(a)

The superintendent shall assure that reserves are reasonable and based on sound actuarial principles with respect to the aggregate dollar amount of reserves for claims that are incurred but not yet paid, and for claims that are incurred but not yet reported.

(b)

The claims will be reported for each calendar year of experience utilized in the rate determination process, but never less than the last three years after the third year of experience is available.

(c)

A plan shall be deemed to comply with the purposes of this section if the expected losses in relation to expected premiums over the entire period for which the plan is rated comply with the requirements of this section and either of the following applies:

(i)

For policies or certificates that have been in force for three years or more, for the last three years, the ratio of incurred losses to earned premiums is greater than or equal to the minimum loss ratios established by this rule.

(ii)

For policies or certificates that have been in force for fewer than three years, the expected third-year loss ratio can be demonstrated to be greater than or equal to the minimum loss ratio.

(7)

Credibility. The certifying actuary shall include a statement related to the credibility of the data and the methodology used to determine such credibility in accordance with the applicable actuarial standards of practice.

(8)

Compliance with minimum loss ratios. Each carrier shall submit to the superintendent an exhibit showing the calculation of the applicable loss ratios and:

(a)

a statement signed by a qualified actuary that the minimum loss ratio requirements have been met; or

(b)

a rate filing to justify the rates, revise rates, modify benefits through a benefit endorsement or to return excess premium.

(9) Corrective action plan. The superintendent may require a corrective action plan to return excess premiums or increase benefits if the minimum loss ratio requirements are not met.

(a)

A carrier shall not return excess premiums per the above guidelines, until the carrier files a corrective action plan and obtains approval of such plan by the superintendent.

(b) If, in the opinion of the superintendent, a plan's failure to meet the minimum loss ratio requirements is due to unusual reserve fluctuations, economic conditions, or other nonrecurring conditions, the superintendent may elect not to issue a corrective action plan. Any such exemption shall be in writing.

[13.10.35.9 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.10 DENTAL PLANS:

A. Applicability. This section applies only to subject dental plans.

B. Definitions. For purposes of this Section:

(1) "Dental plan" is a policy, contract, agreement or arrangement under which an entity undertakes to reimburse claims for the cost of dental services and dental supplies.

(2) "Dental service" means a professional service rendered by a person duly licensed under the laws of this state to practice dentistry or dental therapy, or dental hygienists or dental hygienists certified in collaborative practice and any service constituting the practice of dentistry under state law.

C. Required minimum benefits. A dental plan shall, at a minimum, provide each covered person benefits for the following dental services and dental supplies.

(1) Diagnostic services. A dental plan shall cover the following diagnostic services [~~with a waiting period of no longer than six consecutive months~~] with no waiting period:

(a)

one clinical oral examination twice per plan year;

(b)

clinical oral examinations when performed as a part of an emergency service to relieve pain and suffering.

(2) Radiology services. A dental plan shall cover the following radiology services with a waiting period of no longer than six consecutive months:

(a)

Bitewing x-rays at least once a year unless greater frequency is deemed medically necessary; and

(b)

Panoramic films or an intraoral-complete series, at least once every five consecutive years.

(3) Preventive services. A dental plan shall cover the following services with no waiting period, subject to the following limitations:

(a) Prophylaxis. A dental plan shall cover at least two prophylaxis services every plan year.

(b) Fluoride treatment. A dental plan shall cover at least one fluoride treatment per calendar year furnished in a health care setting for children up to 14 years old or older as medically necessary.

(c) Molar sealants. A dental plan shall cover one treatment of molar sealant per tooth every five consecutive years as medically necessary. A dental plan may exclude coverage where an occlusal restoration has been completed on the tooth. A dental plan may apply a waiting period of six consecutive months for medically necessary sealants.

(4) Cavities. A dental plan shall cover necessary fillings for cavities. A dental plan may not apply a waiting period for cavity fillings.

[~~**(5)** Craniomandibular and temporomandibular joint disorders. A dental plan sold in conjunction with a qualified health plan shall cover the diagnosis and treatment of craniomandibular and temporomandibular joint disorders, if such coverage is not offered by the qualified health plan.~~]

D. Maximum out-of-pocket. To be certified for sale on New Mexico's health insurance exchange, a dental plan shall comply with any federally mandated maximum out-of-pocket limits for dental plans.

[13.10.35.10 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.11 VISION PLANS:

A. Applicability. This section only applies to subject vision plans.

B. Definitions. For purposes of this section:

(1) "covered materials" means materials that are reimbursable by a vision plan to a vision care provider subject to any deductible, copayment, coinsurance, or other plan limitation;

(2) "covered services" means services that are reimbursable by a vision plan vision plan to a vision care provider subject to any deductible, copayment, coinsurance, or other plan limitation;

(3) "materials" means ophthalmic devices, including;

(a) lenses;

(b) frames;

(c) contact lenses; and

(d) spectacle or contact lens treatments and coatings;

(4) "noncovered materials" means materials that are not covered by a vision plan;

(5) "noncovered services" means services that are not covered by a vision plan.

(6) "vision services" means services provided by a vision care provider;

(7) "vision plan" is a policy, contract, agreement or arrangement under which an entity undertakes to reimburse claims for the cost of vision services or vision materials; and

(8) "vision care provider" means an individual licensed under state law as an optometrist or ophthalmologist.

C. Required minimum benefits. A vision plan shall provide each covered person benefits for the following vision services and vision materials. [~~A pediatric vision plan sold in conjunction with a qualified health plan shall provide vision coverage mandated by law for the qualified health plan, or the benefits mandated by this rule, whichever are most favorable to the member.~~]

(1) Examinations. At least once every consecutive two-year period for adults and once every 12-month consecutive period for children under the age of 19, a comprehensive vision examination. The comprehensive vision examination shall include a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities.

(2) Lenses. If the vision examination indicates that corrective lenses are necessary, each covered person is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular as medically necessary and up to the stated benefit limit of the plan. This benefit may be limited to once each two-year consecutive period, unless medical necessity requires increased frequency, and may be subject to a maximum one-month waiting period.

(3) Contact lenses shall be covered as follows:

(a) Medically necessary contact lenses shall be covered in full, up to a benefit maximum, subject to prior authorization from the vision plan [~~if dispensed or provided by an in-network provider or vendor~~].

(b) A vision plan shall provide an elective contact lens allowance up to the stated benefit limit of the plan.

(c) This benefit may be limited to once each 12-month consecutive period and may be subject to a maximum one-month waiting period.

D. Noncovered services and materials. A vision plan may exclude coverage for the following services and materials:

(1) any that are not medically necessary;

(2) any that were not obtained in compliance with the requirements of the vision plan;

(3) any medical or surgical treatment of the eyes;

(4) vision therapy; and

(5) two pairs of glasses in lieu of bifocals.

[13.10.35.11 NMAC - N, 01/01/2022; A, 01/01/2024]

13.10.35.13 COVERAGE DOCUMENTATION:

A. Coverage forms and benefits disclosures.

(1) [~~A carrier shall issue a policy, certificate of coverage or summary of benefits to each covered person on or before the effective date of coverage or of a change in coverage. Covered groups may distribute a certificate of coverage or summary of benefits on behalf of the carrier.~~] A carrier shall issue a policy, certificate of coverage or summary of benefits to each covered person on or before the effective date of coverage or of a change in coverage. Covered groups may distribute a certificate of coverage or summary of benefits on behalf of the carrier.

(2) The policy, certificate of coverage or [~~summary~~] schedule of benefits shall include a clear and complete statement of:

(a) the covered services, supplies and materials;

(b) any limitations or exclusions including any charge, deductible or copayment feature;

(c) [~~where and in what manner information is available as to how services may be obtained;~~] cost-sharing features must be written from the perspective of the insured;

(d) [~~a clear and understandable description of the method for resolving a covered person's complaint.~~] where and in what manner information is available and as to how services may be obtained;

(e) [~~conditions for renewal and reinstatement;~~] a clear and understandable description of the method for resolving a covered person's complaint;

(f) [~~procedures for filing claim~~] a reinstatement provision which states that when premium is not paid within the applicable grace period, a subsequent acceptance of premium by the insurer or their agent without requiring an application for reinstatement, shall reinstate the policy. However, if the insurance company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application, lacking such approval, upon the 30th day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application;

(g) [~~a statement of the amounts payable to the carrier by a covered person and the times at which the amounts shall be paid;~~] a clear and understandable description of the conditions for renewal;

(h) [~~the period during which the plan is effective; and~~] procedures for filing claims;

(i) [~~on the front page, the identity of the carrier.~~] statement of the amounts payable to the carrier by a covered person and the times at which the amounts shall be paid;

(j) the period during which the plan is effective; and

(k) on the front page, the identity of the carrier.

(3) Any subsequent change in coverage or premium shall be explained in a separate document delivered to the covered person.

(4) PPO and indemnity plans cannot be combined and must be submitted in separate product filings.

B. Notice required. If the company sends a separate schedule of benefits to the insured, [~~The~~] the following language shall be provided [~~in a summary of benefits~~] in the separately issued schedule of benefits:

READ YOUR PLAN CAREFULLY - THIS BENEFITS SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU [~~UPON YOUR REQUEST TO US~~].

C. Contact information. The policy, certificate [~~or summary of benefits~~] and schedule of benefits, if issued separately, shall state the plan's contact information and the website and phone number [~~of the office of superintendent of insurance~~] for OSI.

D. Insurance cards. Basic consumer information, including the phone number and website of the insurer's consumer assistance bureau, shall be included on all newly-issued physical or digital insurance cards. Carriers may issue digital cards, but shall provide a physical card upon the request of the consumer.

[13.10.35.13 NMAC - N, 01/01/2022; A, 01/01/2024]

History of 13.10.35 NMAC: [RESERVED]

WORKERS COMPENSATION ADMINISTRATION

The Workers' Compensation Administration Director, on 12/8/2022, repealed the rule 11.4.4 NMAC, Claims Resolution, filed 11/14/2017, and replaced it with 11.4.4 NMAC Claims Resolution, effective 1/1/2023.

The Workers' Compensation Administration Director, on 12/8/2022, repealed the rule 11.4.7 NMAC, Payment for Health Care Services, filed 12/13/2013, and replaced it with 11.4.7 NMAC Payment for Health Care Services, effective 1/1/2023.

WORKERS COMPENSATION ADMINISTRATION

TITLE 11 LABOR AND WORKERS COMPENSATION
CHAPTER 4 WORKERS' COMPENSATION
PART 4 CLAIMS RESOLUTION

11.4.4.1 ISSUING AGENCY: Workers' Compensation Administration ("the WCA").
[11.4.4.1 NMAC - Rp, 11.4.4.1 NMAC, 1/1/2023]

11.4.4.2 SCOPE: These rules apply to parties involved in claims arising under the Workers' Compensation Administration Act and Occupational Disease and Disablement Law (collectively "the act").
[11.4.4.2 NMAC - Rp, 11.4.4.2 NMAC, 1/1/2023]

11.4.4.3 STATUTORY AUTHORITY: Section 52-5-4 NMSA 1978 authorizes the director to adopt reasonable rules and regulations for effecting the purposes of the act.
[11.4.4.3 NMAC - Rp, 11.4.4.3 NMAC, 1/1/2023]

11.4.4.4 DURATION: Permanent.
[11.4.4.4 NMAC - Rp, 11.4.4.4 NMAC, 1/1/2023]

11.4.4.5 EFFECTIVE DATE: January 1, 2023, unless a later date is cited at the end of a section.
[11.4.4.5 NMAC - Rp, 11.4.4.5 NMAC, 1/1/2023]

11.4.4.6 OBJECTIVE: The objective of 11.4.4 NMAC is to establish rules governing the resolution of claim disputes under the act, including but not limited to the process for filing and service of pleadings and the conduct of mediation conferences, discovery, and formal hearings.
[11.4.4.6 NMAC - Rp, 11.4.4.6 NMAC, 1/1/2023]

11.4.4.7 DEFINITIONS: See 11.4.1.7 NMAC.

A. "Initial pleading" means a workers' compensation complaint, application to workers' compensation judge, application to director, petition for lump sum payment, or notice of change of HCP that opens or reopens an action or case before the WCA.

B. "Insurer" means any workers' compensation insurance carrier, a self-insured association or group, an individual self-insured employer, or a third-party claims administrator operating in the state of New Mexico.

C. "Party representative" means an individual or firm that enters an appearance before the WCA to represent or advocate on behalf of a named party. This may include attorneys licensed to practice law in the state of New Mexico, as well as claims administration or adjusting personnel.
[11.4.4.7 NMAC - Rp, 11.4.4.7 NMAC, 1/1/2023]

11.4.4.8 OMBUDSMAN RULES:

A. An ombudsman shall provide information and facilitate communication regarding the act. An ombudsman is required to maintain a neutral position when providing information or facilitating communication. When responding to inquiries, an ombudsman shall:

(1) confer with workers, employers, insurers, HCPs or other interested persons;

(2) provide information or facilitate communication, when requested, about:

(a) individual rights and responsibilities established by the act;

(b) medical proof required to establish or deny the right to workers' compensation;

(c) HCP selection;

(d) mediation conferences, related forms, and other administrative practices and procedures;

(e) determination of disability;

(f) the right to representation by a lawyer or the right to proceed as a pro se party; and

(g) other disputes arising under the act;

(3) help workers, employers, insurers, HCPs or other interested parties complete administrative forms for submission to the administration;

(4) actively inquire into matters presented by workers, employers, insurers, HCPs or other interested persons. An ombudsman shall contact the parties involved and attempt to resolve the problem informally; and

(5) refer all inquiries concerning uninsured employers to the WCA employer compliance bureau.

B. When responding to inquiries, an ombudsman shall not:

(1) practice law or give legal advice;

(2) act as an advocate for any person;

(3) attend a mediation conference as a representative of a party;

(4) provide assistance to any party after the filing of a rejection of a recommended resolution;

(5) provide assistance to a party represented by an attorney;

(6) offer an opinion on whether to accept or reject a settlement offer or a recommended resolution; or

(7) be called as a witness in a mediation conference or adjudication proceeding before a WCA judge.
[11.4.4.8 NMAC - Rp, 11.4.4.8 NMAC, 1/1/2023]

11.4.4.9 FILING AND SERVICE:

A. General provisions:

(1) WCA employees shall be addressed in a courteous and respectful manner at all times.

(2) Unless otherwise stated or necessarily implied in these rules, the rules of civil procedure for the district courts of New Mexico shall apply to and govern all proceedings conducted pursuant to these rules.

(3) Pleadings filed with the WCA Clerk shall:

(a) include a caption identifying the state of New Mexico workers' compensation administration as the legal forum, the name of each party, a descriptive title of the document, and the WCA case number if one has been assigned; and

(b) contain a signature block which includes the signature of the party in interest or party representative(s) followed by the typewritten name(s), the mailing address, telephone number with area code and email address.

(4) Duplicate or multiple copies of the same pleading shall not be filed. Duplicate copies will not be docketed and may be destroyed.

(5) Amended or subsequent pleadings shall be clearly identified (e.g., "Second Complaint").

(6) Pleadings shall not be submitted to the clerk by facsimile transmission.

(7) Pleadings shall not be submitted with cover letters or correspondence.

(8) Parties shall use the mandatory forms available on the WCA website. Items on the mandatory forms may not be deleted, but additional information may be provided at the end of the text. Mandatory forms include:

(a) workers' compensation complaint;

(b) summons for workers' compensation complaint;

(c) worker's authorization for use and disclosure of health records;

(d) informal response to workers' compensation complaint;

(e) notice of acceptance or rejection of recommended resolution;

(f) application to workers' compensation judge;

(g) summons for application to workers' compensation judge;

(h) subpoena or subpoena duces tecum;

(i) request for setting;

(j) health care provider disagreement form;

(k) petition for lump sum payment;

(l) summons for petition for lump sum payment;

(m) joint request for expedited hearing;

(n) application to director; and

(o) summons for application to director.

(9) Filing of initial pleadings:

(a) The workers' compensation complaint shall be filed with a summons and, if filed by a worker, with an executed authorization to release the worker's medical information.

(b) The application to judge, application to director, or petition for lump sum payment shall be filed with a request for setting. A summons shall also be filed if no service of process has previously occurred in the case.

(10) WCA clerk's review of submitted pleadings:

(a) The clerk may reject pleadings that do not conform to these rules. Rejected pleadings will not be filed and will be destroyed.

(b) The clerk shall promptly notify the filing party or party representative of a rejection and the reason(s) for the rejection.

(c) The clerk's rejection of a pleading does not extend or stay the period in which a pleading is due or otherwise delay an applicable deadline.

(d) Reasons for rejecting a pleading may include, but are not limited to:

(i) the caption, WCA number, or party information is not correct;

(ii) the pleading is unsigned;

(iii) the document is incomplete or pages are missing;

(iv) the document is of such poor quality making the content unreadable;

(v) the pleading was not submitted on a mandatory form; and

(vi) initial pleadings to open or reopen the case were not submitted.

B. Electronic Filing:

(1) Effective January 1, 2018, unless exempted herein, all pleadings filed with the WCA shall be filed, served, and received by electronic means through the electronic filing portal on the WCA website.

(2) Electronic filing is not mandatory for pro se workers or for uninsured employers; however, pro se workers and uninsured employers are encouraged to register and use the WCA electronic filing portal. It shall be the duty of all parties not participating in electronic filing to keep the WCA clerk of the court informed of any change in mailing address while they are a party to a proceeding pending before the WCA.

(3) All insurers providing workers' compensation coverage in New Mexico shall register with the WCA with a single, general delivery, e-mail address for receipt of documents including initial pleadings. Insurers shall promptly update the WCA on any changes to the registered email address. Insurers shall confirm annually with the WCA, within the first two weeks of a new calendar year, their mailing address, phone number, and general delivery email address for service of documents. Non-compliance with registration and updating requirements may result in a referral for an administrative investigation and enforcement by the enforcement bureau.

(4) All party representatives, including attorneys and adjusters, shall register with the WCA with a single, general delivery, e-mail address and thereby consent to receive documents from other party representatives and the WCA at that address. Party representatives shall promptly update the WCA on any changes to the registered email address.

(5) Registered parties shall be familiar and comply with the WCA electronic filing requirements set forth in the WCA's electronic filing user guide available on the WCA website.

(6) The WCA shall not be responsible for inoperable email addresses, unread email, or undeliverable emails.

(7) Pleadings filed through the WCA electronic filing portal shall contain the electronic signature of the party in interest or party representative denoted by either a graphic version of the signature or an "s/" followed by signatory's typewritten name.

(8) The date that a pleading is filed through the WCA electronic filing portal is the filing date for the purpose of filing deadlines. For purposes of electronic transmission, a day begins at 12:01 a.m. and ends at midnight.

(9) Registered parties shall have access through the WCA electronic filing portal to case documents after the final date of disposition in accordance with WCA electronic storage capabilities. The clerk shall provide paper copies of pleadings to parties and party representatives upon receipt of a records request. The clerk shall charge a reasonable fee for each copy requested. If the requested copies are mailed, adequate postage for mailing must be paid to the clerk.

C. Service of process:

(1) Initial pleadings:

(a) The clerk shall serve initial pleadings on a responding party. Service shall be accomplished through the WCA electronic filing system for registered parties or by certified mail for pro se workers or uninsured employers who have not registered to use the WCA electronic filing system. When the clerk's attempt at service is unsuccessful, the clerk shall notify the filing party using the e-mail address or postal address provided at the time of filing. The filing party shall then be responsible for service on the responding party.

(b) An employer's insurer is the employer's registered agent for service of process of an initial pleading. If an employer is uninsured, the initial pleading shall so state and the clerk shall then serve the uninsured employer and the uninsured employers' fund separately.

(2) All other pleadings:

(a) All pleadings generated by the WCA, including but not limited to orders and notices, shall be electronically served by the clerk except that the clerk shall serve all unregistered pro se workers and uninsured employers by U.S. mail.

(b) The clerk shall serve notice of all other filed pleadings on registered parties and the parties shall be responsible for logging into the WCA electronic filing portal to access said pleadings.

(c) Unregistered pro se workers and uninsured employers shall be responsible for service on all parties of record. Service on unregistered pro se workers and unregistered uninsured employers shall be the responsibility of the filing party.

D. The clerk shall accept a notice of lien filed by the child support enforcement bureau of the New Mexico department of human services. The notice of lien shall state the worker's name and social security number, and the total dollar amount of the lien. The notice of lien shall include a copy of the district court order requiring the payment of child support by the worker.

[11.4.4.9 NMAC - Rp, 11.4.4.9 NMAC, 1/1/2023]

11.4.4.10 MEDIATION RULES:

A. Mediation of complaints:

(1) The director's designee, a mediator, shall evaluate all initial complaints in new cases.

(2) The mediator shall evaluate and mediate the merits of the complaint for jurisdiction, proper parties, compensability, the nature and extent of any benefits due the worker, and the strength or availability of any defenses. A mediator may also evaluate the compliance of the parties with the mediation rules.

B. Mandatory production:

(1) The purpose of mandatory production is to ensure that the parties and the mediator have access to all pertinent information regarding the issues disputed in the complaint.

(2) No later than five days before the mediation, the parties shall exchange all of the following within the parties' possession:

(a) medical records, including unpaid bills;

(b) payroll records, including average weekly wage calculations;

(c) job description;

(d) witness statements;

(e) documents and correspondence regarding the initial selection of HCP;

(f) indemnity and payment ledgers; and

(g) any other documents related to a claim or defense.

(3) The documents outlined above need not be produced if they are unrelated to a claim or defense, were previously produced, or if there is a good faith objection or privilege.

(4) Parties shall deliver mandatory production and an exhibits list directly to the

mediation bureau no less than five days before the scheduled mediation conference. Mandatory production delivered to the mediation bureau shall not be part of the case record, although parties may file a notice with the clerk indicating compliance with the rule. Mandatory production shall be destroyed by the WCA following issuance of the recommended resolution.

C. Mediation conferences:

(1) Responses:

(a) Respondent shall file an informal response to the complaint not less than five days prior to the mediation conference.

(b) The response shall include a statement of facts and affirmative defenses together with a short summary of reasons for denials of any benefits claimed.

(c) Respondent may file an answer as set forth in this rule, in lieu of an informal response.

(2) By agreement, and subject to the mediation bureau calendar, the parties may reschedule a mediation conference to occur within 75 days of filing the complaint. In doing so, the parties stipulate to waiving the 60-day requirement for the WCA to issue a recommended resolution. Requests by the parties to reschedule a conference that is set in less than five days will only be granted upon demonstration of good cause shown as determined by the mediation bureau chief.

(3) Mediation conferences shall be held using an online web platform and/or telephonic conferencing. At least five days before the scheduled conference, any party may request an in-person mediation conference. All parties must agree to an in-person mediation conference, or it must be approved by the director or director's designee. If the mediation conference is held through an online web platform, the parties will enable and use video, if available. Recording of mediation conferences is prohibited.

(4) The mediator may recommend an amendment to the caption of the complaint to correct an improperly named party or to reflect the joining of appropriate parties who otherwise have notice or attended the mediation conference.

(5) Purposes of mediation conferences and duties of the mediator:

(a) to bring the parties together and attempt to negotiate or settle disputed issues by discussing the facts and applicable law pertaining to the complaint and by suggesting compromises using mediation and other dispute resolution techniques;

(b) to define, evaluate, and make recommendations on all issues remaining in dispute;

(c) to state an opinion of the strength of any argument or position, and the possible results if the complaint is tried by a judge;

(d) to issue a recommended resolution within 60 days of the filing of the complaint unless waived by the parties;

(e) to identify all potential parties;

(f) to make a recommendation regarding attorney's fees; and

(g) to refer any violation of these rules or the act to the enforcement bureau for administrative investigation and enforcement, if appropriate.

(6) Parties are encouraged to communicate before the mediation conference and, if possible, reach a stipulated agreement, of terms to resolve the complaint. When submitting their proposed stipulated agreement to the mediation bureau the parties should utilize the stipulated recommended resolution form provided on the WCA website. If the stipulated agreement is provided before the mediation conference and is adopted by the assigned mediator, the mediation conference will be vacated, and the stipulated recommended resolution will be filed with the clerk of the court. A scheduled mediation conference can only be vacated at the direction of the assigned mediator or mediation bureau chief.

(7) Conduct of mediation conferences:

(a) Mediation conferences shall be in the control of the mediator.

(b) Each party shall come to the mediation conference prepared to discuss settlement of the case. Parties will ensure that they are available for the entirety of the time scheduled for the mediation conference and will ensure that if they are participating through an online web platform or telephonically that there are no background distractions.

(c) The mediator shall be addressed in a courteous and respectful manner by all parties.

(d) Mediation conferences are informal meetings with no transcript of the proceedings. No motions practice shall be allowed. Conferences shall be conducted in a civil, orderly manner, with all presentation geared towards discussion and negotiation of disputed issues. Attorneys and other representatives of the parties shall be attired in an appropriate manner, suitable to a court proceeding.

(e) Employer and attorney, or a representative if no attorney has entered an appearance, and worker and attorney, if any, shall attend the mediation conference. If a party fails to attend a scheduled mediation conference without a reasonable excuse as determined by the mediator, the mediator may still file a recommended resolution based upon the information provided by the attending party and applicable workers' compensation law. If the non-attending party rejects the recommendation, the assigned workers' compensation judge in the interest of justice may refer the matter back to mediation.

(f) Appearances by a legal assistant, paralegal, or other agent or employee of the attorney, in lieu of a personal appearance by an attorney, are prohibited. This rule does not prohibit the appearance of an employer through an adjuster or third-party administrator, nor does it prohibit a worker from attending a mediation conference with the assistance of an unpaid assistant. The attendance and level of participation of any other person at the mediation conference is subject to the discretion of the mediator.

(g) All issues may be considered at the discretion of the mediator when consistent with the goals of economy and fairness, and when an opportunity can be granted for additional response.

(h) The parties are encouraged to prepare written narratives and summaries to assist the mediator.

D. Recommended resolutions:

(1) The mediator shall file the recommended resolution within 60 days of the filing of the complaint unless the parties have stipulated to a waiver of the 60-day requirement and the mediator approves. The mediator may allow additional time to supplement the file prior to issuance of the recommended resolution.

(2) The clerk shall serve a copy of the recommended resolution on parties.

(3) Service on an unregistered party by certified mail domestic return receipt with a signature and date of receipt shall create a presumption of receipt of the recommended resolution on the indicated date. Service through My E-File shall create a presumption of receipt upon transmission.

(4) An acceptance or rejection of the recommended resolution must be filed with the WCA clerk on or before the 30th day after receipt of the recommended resolution. A rejection shall contain a statement of the party's reasons for rejecting the recommended resolution.

(5) Effect of recommended resolution:

(a) The recommended resolution and its terms are not binding and do not reflect an agreement between the parties until all parties have accepted the recommendation or fail to timely reject the recommended resolution.

(b) A rejection in whole or in part of a recommended resolution shall result in assignment to a judge for a determination of all issues in a formal hearing.

(c) Once a party has filed an acceptance or a rejection of a recommended resolution, the party is bound to the acceptance or rejection, unless permitted to withdraw it by written order of the director. The party requesting leave to withdraw a previously filed acceptance or rejection shall submit a written application and proposed order to the director, reciting good cause, within 30 days following receipt by that party of the recommended resolution. The clerk may cancel any judge assignment when a rejection is withdrawn.

(d) If a rejection appears to be untimely, the clerk shall notify the parties of the untimeliness. A party requesting that a rejection be considered timely shall submit a written application to the director and proposed order within 60 days of receipt of the recommended resolution. The application shall state the grounds to support a finding of excusable neglect.

E. Penalties:

(1) Willful failure or refusal to participate in the mediation process shall not preclude the issuance of a recommended resolution, and may constitute bad faith or unfair claims processing.

(2) The assigned mediator, or any party, may refer any such violation for administrative investigation and enforcement by the enforcement bureau.

(3) Failure to comply with the mediation rules, including those requiring mandatory production of evidence and submission of an informal response five (5) days prior to the mediation conference, may subject a party or party's representative to penalties as provided in the Act or the rules of the WCA.

F. Amendment of recommended resolution: The recommended resolution may be amended by a mediator or by the agreement of the parties within the time allowed for acceptance or rejection of a recommended resolution, which time shall not be expanded or modified in any way by the issuance of an amended recommended resolution.

G. A mediator's notes taken in conducting a mediation conference are confidential, not subject to discovery, and shall not be admissible as evidence in any legal proceeding. A mediator may not be called to testify in a workers' compensation or other proceeding regarding a mediation conference they facilitated.

[11.4.4.10 NMAC - Rp, 11.4.4.10 NMAC, 1/1/2023]

11.4.4.11 DIRECTOR'S MATTERS:

A. The following matters shall be pleaded on the mandatory application to director form:

(1) judge assignment disputes;

(2) request for relief from an untimely rejection of a recommended resolution;

(3) request to withdraw an acceptance of a recommended resolution;

(4) appointment of a recipient of benefits for a minor child or an incompetent worker;

(5) approval of an out of state health care provider, if necessary;

(6) attorney withdrawal when no judge is assigned;

(7) objection to case management or utilization review by the WCA; and

(8) any other matter within the director's jurisdiction.

B. A party responding to an application to the director may submit a written response.

C. Recipient of benefits for minors and incompetent workers:

(1) General provisions.

(a) "Recipient" means the individual or entity approved to receive benefit payments on behalf of a minor child or incompetent worker pursuant to Section 52-5-11 NMSA 1978.

(b) The director may designate a judge to resolve applications brought pursuant to Section 52-5-11 NMSA 1978 when other matters are pending before the judge.

(2) Designation of recipient.

(a) An application to the director and request for setting shall be filed and accompanied by a summons if one has not previously been issued in the case.

(b) The application shall have attached any applicable marriage certificate, birth certificates for all known minor children, or a record reflecting worker's incompetency.

(c) The proposed recipient shall provide a copy of a driver's license or other state issued identification at the hearing.

(d) When it is in the best interests of the minor child or incompetent worker, the director may designate a recipient who does not have care, custody, and control of a minor or incompetent worker.

(e) When it is in the best interests of a minor child or incompetent worker, the director may designate a professional or corporate recipient for a minor or incompetent worker. The employer shall pay reasonable administrative fees requested by the alternative recipient and approved by the director.

(f) As a condition of appointment, the recipient must agree to manage and protect benefit payments for the benefit of the minor child or incompetent worker.

(g) A minor child who has reached the age of 16 may apply to the director to receive benefit payments directly.

(3) Accounting of benefits.

(a) The director may require an accounting of how benefits were used on behalf of a minor child or incompetent worker. Unless otherwise ordered by the director, accountings shall be submitted on the approved form and shall be submitted quarterly for the first year and annually thereafter.

(b) The director may suspend benefit payments, in whole or in part, for failure to provide the ordered accounting of benefits or failure to comply with any other condition placed on the recipient.

[11.4.4.11 NMAC - Rp, 11.4.4.11 NMAC, 1/1/2023]

11.4.4.12 HCP RULES:

A. HCP general provisions:

(1) These rules apply to claims governed by the 1990 amendments to the act.

(2) The assigned judge shall decide HCP choice disputes. If no judge has been assigned, a judge shall be appointed by the clerk solely to resolve the HCP dispute.

(3) The HCP judge appointed by the clerk is not assigned pursuant to Subsection C of Section 52-5-5 NMSA 1978. The peremptory right to disqualify a judge allowed by Subsection D of Section 52-5-5 NMSA 1978, does not apply to the appointment of the HCP judge.

B. HCP choice:

(1) Emergency care: The provision of emergency medical care shall not be considered a choice of a treating HCP by the employer or worker.

(2) Selection of HCP:

(a) The employer shall decide either to select the initial HCP or to permit the worker to select the initial HCP. The decision made by the employer shall be made in writing to the worker. Employer may communicate the decision to select the initial HCP or to permit the worker the selection by any method reasonably calculated to notify workers. The employer may use a wallet card, a poster stating the decision posted with the WCA poster, a flyer inserted semi-annually with pay checks, or any other method employer reasonably believes will be successful in alerting the worker.

(b) If the decision of the employer is not communicated in writing to the worker, then the medical care received by the worker prior to written notification shall not be considered a choice of treating HCP by either party.

(c) Medical treatment provided to the worker prior to the employer's written communicated decision to either select the HCP, or to permit the worker to select the HCP, shall be considered authorized health care, the cost of which shall be borne by the employer.

(d) If a provider not licensed in New Mexico treats a worker, the employer must, upon receipt of the initial billing from that provider, either request approval of the out-of-state HCP pursuant to the act, or immediately notify the worker in writing that the provider is not acceptable pursuant to Section 52-4-1 NMSA 1978.

C. Referrals by an authorized HCP:

(1) A referral by an authorized HCP to another HCP shall be deemed a continuation of the selection of the referring HCP.

(2) The 60 day effective period allowed in Subsection

B of Section 52-1-49 NMSA 1978, is not enlarged by the HCP's referral.

D. Notice of change of HCP:

(1) The 60 day period of initial HCP choice shall run from the date of first treatment or examination by, or consultation with, the initial HCP.

(2) The notice of change of HCP shall provide:

(a) name, address and telephone number of worker, employer and insurance carrier, if any;

(b) date and county of accident;

(c) nature of injury;

(d) the names, addresses and telephone numbers of the current and proposed HCPs;

(e) the signature of the party requesting the change of HCP; and

(f) the following text: "your rights may be affected by your failure to respond to this notice; if you need assistance and are not represented by an attorney, contact an ombudsman of the WCA."

(3) After 50 days of the initial 60 day period, the party denied the initial selection may give notice of change of HCP.

E. Issuance of notice of change: The party seeking the change of HCP shall issue a notice of change of HCP. A copy of the notice shall be provided to the other party 10 days prior to provision of any medical treatment by the proposed HCP.

F. Effective date of notice of change:

(1) The notice of change shall be effective, unless an objection is filed with the clerk within three days from receipt of the notice of change. A copy of the notice of change shall be attached to any objection filed with the clerk. If no objection is filed, the HCP declared on the notice of change form shall be designated as the authorized treating HCP and may begin treating the worker 11 days after issuance of the notice of change.

(2) An objection can be filed after the three day period, but any bills incurred for medical treatment rendered after the effective date of the notice of change and prior to a ruling by the judge on the objection shall be paid by the employer. A party required to pay for medical treatment pursuant to this rule shall not be deemed to have waived any objections to the reasonableness or necessity of the treatment provided.

G. Responsibility for payment of HCP services:

(1) The employer shall be responsible for all reasonable and necessary medical services provided by an authorized HCP from the date the notice of change is effective.

(2) The worker shall be responsible for any medical services rendered by an unauthorized HCP.

(3) The designation of an authorized HCP shall remain in effect until modified by agreement of the parties or by order of the judge.

(4) Effective July 1, 2013, all medical services rendered pursuant to recommended treatment contained in the most recent edition of the official disability guidelines™ (ODG) is presumed reasonable and necessary; there is no presumption regarding any other treatment.

H. Reasonable and necessary disputes: Disputes concerning the reasonableness and necessity of prescribed treatment may be brought before the administration pursuant to 11.4.7.11 NMAC.

I. Hearing on objection to notice of change: If an objection to notice of change of HCP is filed with the clerk, the objection shall be heard by the judge within seven days from the filing of the objection. The judge may issue a minute order at the conclusion of the hearing on the objection.

J. Request for change of HCP: If a disagreement arises over the selection of a HCP, and the parties cannot otherwise agree, a request for change of HCP must be submitted to the clerk. The request for change of HCP may be submitted at any time, including the initial 60 day period.

K. Request for change of HCP form:

(1) The request for change of HCP must state the specific reasons for the requested change.

(2) The request for change of HCP may suggest an alternative HCP's name.

L. Burden of proof: The applicant requesting a change of HCP must prove the authorized HCP is not providing the worker reasonable and necessary medical care. If the applicant fails to establish the provision of medical care is not reasonable, the request for change shall be denied.

M. Hearing on request for change of HCP: The request for change of HCP disagreement shall be heard by the judge within seven days from the filing of the request for change of HCP. The judge may issue a minute order at the conclusion of the hearing on the request for change. [11.4.4.12 NMAC - Rp, 11.4.4.12 NMAC, 1/1/2023]

11.4.4.13 ADJUDICATION PROCESS:

A. Assignment of judge:

(1) Upon receipt of a timely rejection of a recommended resolution, an application to judge or petition for lump sum payment, the clerk shall assign a judge to the case and shall serve notice on all parties. Pro se parties shall be served by certified mail unless registered with the WCA electronic filing system. This notice shall be considered the initial notice of judge assignment.

(2) Each party shall have the right to disqualify a judge by filing a notice of disqualification of judge no later than 10 days from the date of filing of the notice of assignment of judge. The clerk shall assign a new judge to the case and notify all registered parties. A party who has not exercised the

right of disqualification may do so no later than 10 days from the filing of the notice of reassignment of judge.

(3) No action may be taken by any judge on a case until the expiration of the time for all parties to exercise the peremptory right to disqualify a judge. To expedite the adjudication process, the parties may file a joint waiver of the right to disqualify a judge. Such waiver shall forever bar the parties' right to disqualify a judge in that case.

(4) Disputes related to the assignment, re-assignment, or disqualification of a judge shall be raised by written application to the director, which shall be filed with the clerk.

(5) The director may designate an on-call judge for the limited purpose of reviewing and approving lump sum payment petitions on a voluntary walk-in basis. The director shall provide notice to the public about the schedule for any on-call judge availability. Such designation shall not be considered a judge assignment or reassignment under this section if further adjudication action is needed.

B. Application to judge:

(1) Unless otherwise provided, all claims under the act shall be initiated by filing a complaint form, and the clerk shall schedule the claim for mediation. A party may file an application to judge, and the clerk shall assign the case to a judge to adjudicate the following limited forms of relief only:

(a) physical examination pursuant to Section 52-1-51 NMSA 1978;

(b) independent medical examination pursuant to Section 52-1-51 NMSA 1978;

(c) determination of bad faith, unfair claims processing, fraud or retaliation;

(d) supplemental compensation order;

(e) award of attorney fees;

(f) stipulated reimbursement agreement pursuant to Section 52-5-17 NMSA 1978;

(g) consolidation of payments into quarterly payments (not a lump sum under Section 52-5-12 NMSA 1978);

(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; or

(i) request for release of medical records.

(2) If any claim not enumerated above is raised on an application to judge, the application shall be deemed a complaint and the clerk shall refer it for mediation.

(3) For an application seeking relief under Subparagraphs (a) (b) (c) (d) (h) or (i) of Paragraph (1) of Subsection A of 11.4.4.13 NMAC above, an application to judge may not be filed if a complaint has been filed in the same case and the time period for acceptance or rejection of the recommended resolution has not yet expired. Any other claim for relief arising during that time period shall be raised in the mediation process.

(4) Following the rejection of a recommended resolution and during the pendency of a complaint, those claims for forms of relief set forth above shall be sought through motion rather than an application.

(5) Responses to an application to a judge, if any, shall be filed within 15 days of service. A response to application to judge may not raise new claims or issues.

(6) All applications to a judge shall be accompanied by a summons, if one has not previously been issued in the case, and a request for setting. Hearings as necessary may be scheduled by the assigned judge.

C. Petition for lump sum payment:

(1) Parties may request approval of a lump sum payment by filing the WCA mandatory petition form, which shall be signed and verified by the worker or the worker's dependents.

(2) Petitions under Subsection D of Section 52-5-12 NMSA 1978 shall also be signed by the employer or its representative or, where applicable, the UEF.

(3) Parties to lump sum payment petitions filed pursuant to Subsection D of Section 52-5-12 NMSA 1978 shall attend a lump sum payment approval hearing for a determination that the agreement is voluntary, that the worker understands the terms, conditions and consequences of the settlement agreement or any release, and that the settlement is fair, equitable and provides substantial justice to the parties. For all other joint lump sum payment petitions, a hearing may be held at the discretion of a judge pursuant to Sections 52-5-12 and 52-5-13 NMSA 1978.

(4) Any lump sum payment petition filed pursuant to this rule shall comply with Section 52-1-54 NMSA 1978 and counsel for the parties may concurrently seek approval or award of attorney fees, if appropriate, to be heard in the context of the lump sum payment hearing.

(5) Written responses to the petition, if any, shall be filed within 10 days of service of a petition.

(6) All petitions shall be accompanied by a request for setting, and a summons, if one has not previously been issued in the case. Such hearings will be promptly scheduled by the assigned judge.

D. The adjudication process for complaints shall commence upon the clerk's receipt of a timely rejection of a recommended resolution. An answer to complaint shall be filed within 20 days of the filing of the initial notice of assignment of judge unless already filed in lieu of the informal response. The answer shall admit or deny each claim asserted in the complaint. Any affirmative defenses to the complaint shall be stated in the answer.

E. Amended complaints may be filed during the adjudication process only by leave of the assigned judge or by written consent of the adverse party. Leave shall be freely given when justice so requires. Amended complaints filed during the adjudication process shall not be referred back to the mediation process nor shall a new recommended resolution be issued.

F. The judge may hold pre-trial conferences as necessary, establish appropriate deadlines, mandate evidentiary disclosures between the parties, approve formal discovery, and otherwise control all other aspects of the adjudication process in order to enable the prompt adjudication of the case.

G. Discovery: Authorized interrogatories, requests for production or inspection, requests for admissions, depositions, and subpoenas shall be governed by the rules of civil procedure of the district courts of New Mexico.

H. Depositions: Upon the filing of a complaint and by written stipulation of the parties, good cause is presumed and depositions may be taken of the worker, employer representative, authorized HCP, and any provider of an independent medical examination.

(1) Reasonable notice shall be deemed to be not less than five days prior to the date set for the deposition.

(2) The original deposition transcript shall be kept by the party who noticed the deposition.

(3) The parties shall make a good faith effort to obtain a completed and signed form letter to HCP prior to setting the deposition of the HCP.

(4) Deposition testimony of authorized HCPs shall be admissible in lieu of live testimony.

(5) Depositions of other witnesses identified by the parties may be admissible, if noticed for use at trial, provided that nothing prohibits either party from issuing a subpoena to order the deposed witness to testify at trial.

(6) A party intending to use a deposition shall notify the other party of the intended use at least 10 days prior to trial. Any objection to the use of the deposition shall be determined at the adjudication hearing.

(7) The party that notices a deposition may request the return of the original transcript after final disposition of the case. The clerk may return a transcript or any exhibits tendered to the submitting party or its attorney. If no request for the deposition or exhibits is received, the deposition or exhibits will be destroyed. Notice of intent to destroy exhibits is published in the New Mexico bar bulletin.

I. Subpoenas: The clerk may issue a subpoena, signed but otherwise blank, to a party requesting it, who shall complete it before service. An attorney authorized to practice law in New Mexico who represents a party before the WCA may also issue and sign a subpoena as an officer of the court on behalf of the WCA.

J. Appointment of interpreter:

(1) It is the responsibility of the parties to determine if interpretive services are necessary.

(2) An interpreter may be appointed by the judge, director, or mediator. The interpreter shall be court-certified, except that a non-certified interpreter may serve at mediation conferences.

(3) The employer shall be responsible for the cost and arrangement of a qualified interpreter for the hearing or mediation conference. This responsibility may fall to the uninsured employers' fund when named as a party.

K. Motions: All motions, except those made in open court, shall be written and comply with the New Mexico district court rules of civil procedure.

L. Settlement/pre-trial conferences: The judge shall have discretion to schedule settlement conferences. A settlement conference facilitated by the assigned judge shall require the consent of all parties either on the record or in writing.

M. Orders: Proposed orders or other documents requiring a judge's signature shall not be filed with the clerk but shall be submitted directly to the judge.

N. Admissibility of evidence:

(1) Live medical testimony shall not be permitted, except by an order of the judge.

(2) A judge may admit evidence, including hearsay evidence, provided that the evidence is relevant, has sufficient indicia of reliability and authenticity, and will assist the judge in determining a fact or issue in dispute, including, but not limited to:

(a) personnel records, payroll records, or other employment files for worker;

(b) pre-injury medical records of treatment received for a period of 10 years prior to the date of injury through the time of hearing on the merits;

(c) form letters approved by the WCA;

(d) records of authorized health care providers and their referrals, including functional capacity evaluations;

(e) reports of independent medical examinations ("IMEs") performed pursuant to the act or as otherwise agreed by the parties;

(f) toxicology or drug and alcohol test reports;

(g) records of the office of medical examiner, including autopsy and toxicology reports; or

(h) records of the New Mexico board of pharmacy prescription monitoring program.

O. Continuance of hearing: A judge may continue an adjudication hearing for good cause shown. All discovery, disclosure, and exchange deadlines shall be extended

by a continuance unless otherwise ordered.

P. Trials and other hearings:

(1) Parties shall appear personally at the adjudication hearing, without the necessity of a subpoena. Parties shall appear personally or through their legal representatives at all other hearings properly noticed, unless excused by a judge.

(2) Failure to appear at a hearing after proper notice and without good cause may result in the imposition of sanctions.

(3) The employer shall make all necessary arrangements and pay all costs incurred for telephonic conference calls. The director or judge may appear telephonically for the conference call.

(4) All hearings shall be recorded by audio tape recording or by any other method approved by the director.

(5) Prior to commencement of the adjudication hearing, the parties shall confer with the court monitor to ensure that all exhibits are properly marked. Any exhibit to be jointly tendered shall be marked and offered as a joint exhibit. All other exhibits shall be marked by party and exhibit number or letter. Depositions shall be marked as exhibits.

(6) Under exceptional circumstances and in the interest of justice, a judge has discretion to direct or allow supplementation of evidence within 10 days of the close of the adjudication hearing.

Q. Consolidated cases:

(1) A judge may order the consolidation of cases when the issues or facts in dispute in the cases are common or when consolidation will expedite resolution of the issues or facts in dispute.

(2) A party may request an order for consolidation of cases by filing a motion requesting consolidation in each case sought to be consolidated and serving each party and their counsel, if any, for each case sought to be consolidated.

(3) Motions to consolidate cases will be adjudicated by the final judge assigned to the case with the lowest case number.

(4) A judge's order of consolidation shall be filed in each consolidated case.

(5) After consolidation, all pleadings shall only be filed in the case with the lowest case number and the case number of each consolidated case shall appear in the caption of all pleadings. The caption of the lowest case number shall appear on all pleadings.

(6) All parties of record and their counsel shall have access to view the filed pleadings for each case.

(7) In the event of an appeal, the notice of appeal shall include the case number for each consolidated case and shall be filed in the case with the lowest case number. The record proper on appeal shall include all pleadings in each of the consolidated cases.

R. Release of medical records:

(1) A judge shall decide medical record disputes. If no judge has been assigned, the clerk shall appoint a judge upon a party filing an application to judge for release of medical records.

(2) An application to judge for the release of medical records shall be allowed notwithstanding the provisions of any other rule, and shall be disposed of separate and apart from all rule provisions and procedures pertaining to resolution of other disputes arising from a claim for benefits.

(3) The judge will determine whether the protected health information in controversy is material to the resolution of any matter presently at issue or likely to be at issue in the administration of the claim and shall order the release of protected health information upon agreement of the parties or a finding of materiality by a preponderance of evidence.

(4) A bench order or formal order of release of medical records shall have the force of law with respect to the parties and to the HCP or medical facility.

(5) If an HCP or medical facility fails to provide records after a judge has ordered the release of records pursuant to this rule, then the party to receive the records may notify the HCP or medical facility through My E-File of the obligation to produce the records and an endorsed copy of the order. If the records are not produced within five days of service of the notice, the payer's obligation to timely pay shall be tolled until the actual production of the records.

(6) If any judge involved in the adjudication of the case finds that the withholding of records of health information after an order to produce has obstructed the efficient administration or adjudication of a case, then the judge may schedule a hearing to determine if the withholding of records was unreasonable. If the judge finds after notice and an opportunity to be heard that the withholding of records by the HCP or medical facility is unreasonable, the director may find the HCP or medical facility in violation of this rule and assess a penalty pursuant to Section 52-1-61 NMSA 1978 (1990).

[11.4.4.13 NMAC - Rp, 11.4.4.13 NMAC, 1/1/2023]

11.4.4.14 WITHDRAWAL AND SUBSTITUTION OF COUNSEL:

A. The entry of appearance of an attorney or a firm for a party in a pending case shall not be withdrawn without permission of the judge or by the director if no judge has been assigned to the case. A motion to the judge or application to director requesting withdrawal shall be filed with the clerk and shall indicate whether the client concurs with the withdrawal.

B. A motion to the judge or application to director seeking withdrawal of counsel shall clearly state whether the withdrawing

attorney is asserting a request for attorneys' fees for services rendered. If no statement is made, and if the motion or application to withdraw is granted, the withdrawing attorney is barred from thereafter seeking attorneys' fees for services rendered on the case. A statement asserting a request for attorneys' fees shall serve as notice to the parties and new legal counsel, if any.

C. When a new attorney assumes a case, a notice of substitution of counsel shall be filed and served on each party. The notice shall contain the new attorney's mailing address, phone number, and e-mail address.

D. The attorney of record shall be subject to notice of hearings or other proceedings until permitted to withdrawal from the case.

[11.4.4.14 NMAC - Rp, 11.4.4.14 NMAC, 1/1/2023]

11.4.4.15 APPROVAL OF ATTORNEY FEES AND LIENS:

A. Parties may request the award of attorney fees by application to a judge. The application must contain sufficient information to determine if the fee requested is appropriate. The contested application should indicate the date and terms of any offers of settlement made; the present value of the benefits awarded the worker, including, but not limited to medical expenses and past and future weekly benefits; the total number of hours reasonably expended by counsel to secure benefits for the worker; the hourly billing rate of counsel; and any other relevant information for the determination of fees.

B. No attorney fees shall be paid until the case has been settled or adjudged. For purposes of the act, settled or adjudged includes:

(1) the entry of a compensation order; or

(2) the acceptance by both parties of a recommended resolution; or

(3) an order granting or denying any petition or application when no other cases are pending before the administration; or

(4) the WCA has administratively closed the file; or

(5) when there is a good faith belief that all pending issues or questions have been resolved, whether or not the jurisdiction of the administration has been invoked.

C. An attorney withdrawing from representation during the pendency of a case and before the case has been settled or adjudged shall assert a request for attorney fees, if any, within the motion to judge or application to director seeking to withdraw as counsel. The request for attorney fees shall not be decided until the case is settled or adjudged.

D. When a subsequent attorney requests attorney fees, the attorney shall give notice to the withdrawn attorney by serving on the withdrawn attorney a copy of all relevant pleadings at the time of filing.

E. No attorney fee lien shall be filed in a case until a judge has awarded fees pursuant to Section 52-1-54 NMSA 1978.

[11.4.4.15 NMAC - Rp, 11.4.4.15 NMAC, 1/1/2023]

11.4.4.16 SANCTIONS:

A. The judge may sanction any party, attorney, or personal representative for conduct that interferes with the orderly administration of the court or a hearing, including, but not limited to:

(1) rejecting a recommended resolution without reasonable basis, or without reasonable expectation of doing better at formal hearing;

(2) failing to obey a lawful order of the court;

(3) failing to appear for a hearing or deposition; or

(4) advancing a meritless position in order to harass or vex the opposing party.

B. The judge will conduct a separate hearing on the imposition of sanctions according to the procedures in this part.

C. As a sanction, the judge may do any or all of the following:

(1) assess reasonable attorney's fees against a party pursuant to Section 52-1-54 NMSA 1978;

(2) reduce the fees of an attorney for a party;

(3) assess prejudgment interest from the date of the recommended resolution in the claim;

(4) strike a claim or defense;

(5) limit the evidence which may be introduced;

(6) dismiss an action;

(7) order the suspension or forfeiture of compensation benefits;

(8) assess expenses and costs against a party; or

(9) impose a civil penalty pursuant to Sections 52-1-28.1, 52-1-28.2, 52-3-45.1 or 52-3-45.2 NMSA 1978.

D. For patterns of misconduct beyond a single case, the judge may refer the matter to the WCA enforcement bureau for further investigation, administrative prosecution and imposition of penalties.

[11.4.4.16 NMAC - Rp, 11.4.4.16 NMAC, 1/1/2023]

11.4.4.17 SEALING OF PUBLIC COURT RECORDS:

A. Public court records filed with the clerk of court or offered as evidence in an administrative or adjudicative hearing shall not be sealed based solely on the agreement or stipulation of the parties.

B. The party requesting to seal court records subject to public inspection shall establish the same requirements for sealing court records as set forth in the rules of civil procedure for the district courts of New Mexico.

C. The order sealing the court records may seal the records from public inspection but shall not prohibit WCA staff from accessing the court record as necessary to enforce the provisions of the act.

[11.4.4.17 NMAC - Rp, 11.4.4.17 NMAC, 1/1/2023]

HISTORY OF 11.4.4 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
WCA 86-1, Informal Hearing Procedures, filed 5/26/1987.
WCD 89-1, Mediation Rules, filed 6/20/1989.
WCA 92-2, Workers' Compensation Administration Mediation Rules, filed 2/24/1992.
WCA 92.2, Rules Governing Mediation, filed 10/30/1992.
WCA 93.2, Rule Governing Mediation, filed 10/28/1993.
WCA 86-2, Formal Hearing Procedures, filed 5/26/1987.
WCD 89-2, Formal Hearing Rules, filed 6/20/1989.
WCA 92.3, Rules Governing Formal Hearings, filed 10/30/1992.
WCA 86-7, Attire, filed 5/26/1987.
WCD 89-7, Attire, filed 6/20/1989.
WCD 89-8, Workers' Compensation Division Forms, filed 6/20/1989.
WCA 91-1, Miscellaneous Proceedings and Preliminary Questions of Fact, filed 1/24/1991.
WCA 91-1, Miscellaneous Proceedings and Preliminary Questions of Fact, filed 5/29/1991.
WCA 92.1, Rules Governing Miscellaneous Proceedings and Preliminary Questions of Fact, filed 10/30/1992.
WCA 93.1, Rules Governing Miscellaneous Proceedings and Preliminary Questions of Fact, filed 10/28/1993.

History of Repealed Material:
11.4.4 NMAC, Claims Resolution, filed 5/20/1996, repealed effective 10/1/2014.
11.4.4 NMAC, Claims Resolution, filed 10/1/2014, repealed effective 1/1/2018.
11.4.4 NMAC, Claims Resolution, filed 12/13/2022, repealed effective 1/1/2023.

WORKERS COMPENSATION ADMINISTRATION

TITLE 11 LABOR AND WORKERS' COMPENSATION
CHAPTER 4 WORKERS' COMPENSATION
PART 7 PAYMENTS FOR HEALTH CARE SERVICES

11.4.7.1 ISSUING AGENCY: Workers' Compensation Administration (WCA).
[11.4.7.1 NMAC - Rp, 11.4.7.1 NMAC, 1/1/2023]

11.4.7.2 SCOPE: This rule applies to workers, employers, and insurers and to all workers' compensation health care services providers, caregivers, pharmacies, and suppliers and all payers for such services and supplies.
[11.4.7.2 NMAC - Rp, 11.4.7.2 NMAC, 1/1/2023]

11.4.7.3 STATUTORY AUTHORITY: Sections, 52-4-2, 52-4-3, 52-4-5, 52-5-4, and NMSA 1978.
[11.4.7.3 NMAC - Rp, 11.4.7.3 NMAC, 1/1/2023]

11.4.7.4 DURATION: Permanent.
[11.4.7.4 NMAC - Rp, 11.4.7.4 NMAC, 1/1/2023]

11.4.7.5 EFFECTIVE DATE: January 1, 2023, unless a later date is cited at the end of a section.
[11.4.7.5 NMAC - Rp, 11.4.7.5 NMAC, 1/1/2023]

11.4.7.6 OBJECTIVE: The purpose of these rules is to establish and enforce a system of maximum allowable fees and reimbursements for health care services and related non-clinical services provided by all practitioners, to establish billing dispute procedures and to establish the procedures for cost containment, including case management, utilization review and Return-to-work (RTW) services.
[11.4.7.6 NMAC - Rp, 11.4.7.6 NMAC, 1/1/2023]

11.4.7.7 DEFINITIONS: The definitions in 11.4.1.7 NMAC shall apply to this rule. In addition, the following definitions apply to the provision of all services.

A. "Business day" means any day on which the WCA is open for business.

B. "By-Report (BR)" means a maximum amount for a service has not been established in the HCP fee schedule.

C. "Cannabis Program" means the State of New Mexico Department of Health Medical Cannabis Program.

D. "Caregiver" means any provider of health care services not defined and specified in Section 52-4-1 NMSA 1978.

E. "Case management" means the on-going coordination of health care services provided to an injured or disabled worker including, but not limited to:

(1) developing a treatment plan to provide appropriate health care service to an injured or disabled worker;

(2) systematically monitoring the treatment rendered and the medical progress of the injured or disabled worker;

(3) assessing whether alternate health care services are appropriate and delivered in a cost-effective manner based upon acceptable medical standards;

(4) ensuring that the injured or disabled worker is following the prescribed health care plan; and,

(5) formulating a plan for the return to work.

F. "Contractor" means any organization that has a legal services agreement currently in effect with the workers' compensation administration (WCA) for the provision of utilization review or case management or peer review services.

G. "Corrected claim" means a claim that has already been processed by the payer, whether paid or denied, and is resubmitted with additional charges, different procedure

or diagnosis codes or any information that would change the way the claim originally processed.

H. "Current procedural terminology ("CPT®")" means a systematic listing and coding of procedures and services performed by HCPs of the American medical association, adopted in the director's HCP fee schedule order. Each procedure or service is identified with a numeric or alphanumeric code (CPT® code). This was developed and copyrighted by the American medical association. The five character codes included in the rules governing the health care provider fee schedule are obtained from current procedural terminology (CPT®), by the American medical association (AMA). CPT® is developed by the American Medical Association (AMA) as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of the rules governing the health care provider fee schedule is with WCA and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in rules governing the health care provider fee schedule. Fee schedules, relative value units, conversion factors or related components are not assigned by the AMA, are not part of CPT®, and AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT® outside of rules governing the health care provider fee schedule should refer to the most recent edition of the current procedural terminology which contains the complete and most current listing of CPT® codes and descriptive terms. Applicable FARS/DRARS apply. CPT® is a registered trademark of the American medical association.

I. "Diagnostic and statistical manual of mental disorders (DSM)" means the current edition of the manual, which lists and describes the scientifically diagnosed mental disorders and is commonly referred to as "DSM".

J. "Department of health (DOH)" means the state of New Mexico department of health.

K. "Director" means director of the workers' compensation administration (WCA) or designee.

L. "Durable medical equipment (DME)" means supplies and equipment that are rented, leased, or permanently supplied to a patient and which have been prescribed to aid the recovery or improve the function of an injured or disabled worker.

M. "Employer" means, collectively: an employer subject to the act; a self-insured entity, group or pool; a workers' compensation insurance carrier or its representative; or any authorized agent of an employer or insurance carrier, including any individual owner, chief executive officer or proprietor of any entity employing workers.

N. "Freestanding ambulatory surgical center (FASC)" means a separate facility that is licensed by the New Mexico department of health as an ambulatory surgical center.

O. "Healthcare Common Procedure Coding System (HCPCS)" means a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT®).

P. "Health care provider (HCP) or provider" means any person, entity, or facility authorized to furnish health care to an injured or disabled worker pursuant to Section 52-4-1 NMSA 1978, including any provider designated pursuant to Section 52-1-49 NMSA 1978, and may include a provider licensed in another state if approved by the director, as required by the act. The director has determined that certified registered nurse anesthetists (CRNAs) and certified nurse specialists (CNSs) who are licensed in the state of New Mexico are automatically approved as health care providers pursuant to Subsection P of Section 52-4-1 NMSA 1978.

Q. "HCP fee schedule" means the WCA Health Care Provider Fee Schedule & Billing Instructions document and is used for ease of reference.

R. "Hospital" means any place currently licensed as a hospital by the department of health pursuant to Subsection A of Section 52-4-1 NMSA 1978, where services are rendered within a permanent structure erected upon the same contiguous geographic location as are all other facilities billed under the same name.

S. "Implants, instrumentation and hardware" means:

(1) surgical implants are defined as any single-use item that is surgically inserted, deemed to be medically necessary and approved by the payer which the physician does not specify to be removed in less than six weeks, such as bone, cartilage, tendon or other anatomical material obtained from a source other than the patient; plates, screws, pins, cages; internal fixators; joint replacements; anchors; permanent neurostimulators; and pain pumps;

(2) disposable instrumentation includes ports, single-use temporary pain pumps, external fixators and temporary neurostimulators and other single-use items intended to be removed from the body in less than six weeks.

T. "Independent medical examination (IME)" means a specifically requested evaluation of an injured or disabled worker's medical condition performed by an HCP, other than the treating provider, as provided by Section 52-1-51 NMSA 1978.

U. "Licensed producer" means an individual or entity located in New Mexico licensed and certified by the department of health to produce, manufacture, or dispense medical cannabis.

V. "Medical cannabis" means medical cannabis

in the form of flower, bud, cannabis derived products, edibles, oils, tinctures, or any other form regulated by the department of health.

W. "Medical records" means:

(1) all records, reports, letters, and bills produced or prepared by an HCP or caregiver relating to the care and treatment rendered to the worker;

(2) all other documents generally kept by the HCP or caregiver in the normal course of business relating to the worker, including, but not limited to, clinical, nurses' and intake notes, notes evidencing the patient's history of injury, subjective and objective complaints, diagnosis, prognosis or restrictions, reports of diagnostic testing, hospital records, logs and bills, physical therapy records, and bills for services rendered, but does not include any documents that would otherwise be inadmissible pursuant to Subsection C of Section 52-1-51 NMSA 1978.

X. "New Mexico gross receipts tax (NMGRT)" means the gross receipts tax or compensating tax as defined in Chapter 7, Article 9 of the New Mexico Statutes Annotated 1978 (the "Gross Receipts and Compensating Tax Act"). This tax is collected by the New Mexico taxation and revenue department.

Y. "Peer review" means an individual case by case review of services for medical necessity and appropriateness conducted by an HCP licensed in the same profession as the HCP whose services are being reviewed.

Z. "Physical impairment ratings (PIR)" means an evaluation performed by an MD, DO, or DC to determine the degree of anatomical or functional abnormality existing after an injured or disabled worker has reached maximum medical improvement. The impairment is assumed to be permanent and is expressed as a percent figure of either the body part or whole body, as appropriate, in accordance with the provisions of the Workers' Compensation Act and the most current edition of the American medical association's guides to the evaluation of permanent impairment (AMA guide).

AA. "Prescription drug" means any drug, generic or brand name, which requires a written order from an authorized HCP for dispensing by a licensed pharmacist or authorized HCP.

BB. "Provider's Report of Physical Ability (PROPA)" means the WCA form available to all parties on the WCA agency website which may be completed by HCPs.

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

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

EE. "Telemedicine services" means a two-way, real time interactive communication between the worker and the provider at a distant site. At a minimum, telemedicine includes audio and video telecommunications equipment.

FF. "Telephonic services" means non-face to face services provided to a patient using the telephone. Such services can include medical discussions, between a physician or other healthcare professional and a patient, that do not require direct, in person contact.

GG. "Unlisted service or procedure" means a service performed by an HCP or caregiver which is not listed in the edition of the American medical association's current procedural terminology referenced in the director's HCP fee schedule order or has not otherwise been designated by these rules.

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

II. "Utilization review" means the evaluation of the necessity, appropriateness, efficiency, and quality of health care services provided to an injured or disabled worker and may include peer group utilization review of selected provider services as set forth in Section 52-4-2 NMSA 1978.

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

[11.4.7.7 NMAC - Rp, 11.4.7.7 NMAC, 1/1/2023]

11.4.7.8 GROUND RULES FOR BILLING AND PAYMENT:

A. Basic ground rules.

(1) These rules apply to all charges and payments for medical, other health care treatment, and related non-clinical services covered by the New Mexico Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law.

(2) These rules shall be interpreted to the greatest extent possible in a manner consistent with all other rules promulgated by the WCA. In the event of an irreconcilable conflict between these rules and any other rules, the more specific set of rules shall control.

(3) Nothing in these rules shall preclude the separate negotiation of fees between a provider and a payer within the HCP fee schedule for any health care service as set forth in these rules.

(4) These rules and the director's HCP fee schedule order adopting the HCP fee schedule utilize the edition of the current

procedural terminology referenced in the director's HCP fee schedule order, issued pursuant to Subsection A of 11.4.7.9 NMAC. All references to specific CPT® code provisions, in these rules shall be modified to the extent required for consistency with the director's HCP fee schedule order.

(5) Employers are required to inform a worker of the identity and source of their coverage for the injury or disablement.

B. Authorization for treatment and services.

(1) A provider or inpatient facility may seek pre-authorization from payer for all services or treatment plans. If authorization is sought, all requests for authorization of referrals and all other procedures shall be approved or denied by the payer within five business days of receipt of all supporting documentation and no later than five business days before the procedure.

(2) Once a worker has been admitted to an inpatient facility, all requests for authorization of referrals and procedures during the inpatient stay shall be approved or denied by the payer by the close of the next business day after receipt of all supporting documentation.

(3) A payer shall not be required to respond to a provider's request for authorization within the deadlines set forth in this rule if the payer has previously denied a claim in writing.

(4) Pre-authorization is required prior to scheduling or performing any of the following services:

(a) independent medical examinations;

(b) physical impairment ratings;

(c) functional capacities evaluations;

(d) physical therapy;

(e) caregiver services; and

(f) durable medical equipment (DME).

(5) Pre-authorization, as outlined in (a) through (f) above, must be obtained by the HCP before services or equipment are provided or the payer will not be held liable for payment of the service or equipment provided.

(6) If an authorization, a pre-authorization or a denial is not received by the provider by the deadlines set forth in this rule, the requested service or treatment will be deemed authorized. The provider and the payer shall document all attempts to obtain authorization from the date of the initial request.

C. Billing provision ground rules.

(1) Billing shall be made in accordance with HCP fee schedule issued by the director in conjunction with the director's HCP fee schedule order.

(2) Submitting a bill to any party for the difference between the usual and customary charges and the maximum amount of reimbursement allowed for compensable health care services or items, also known as balance billing, is prohibited.

(3) Coding and billing separately for procedures that do not warrant separate identification because they are an integral part of a service for which a corresponding CPT® code exists, also known as unbundling, is prohibited.

(4) The appropriate CPT® code must be used for billing by providers.

(5) Initial billing of outpatient services by providers, hospitals and FASC's, shall be submitted no later than 60 days from the date on which services were rendered. Initial billing of inpatient services shall be issued no later than 60 days from the date of discharge.

(6) A HCP's documented, good faith effort to bill within the time-limits provided by these rules shall not constitute untimely filing.

(7) Failure of the provider to submit billing, or to demonstrate a good faith effort to submit billing, within the time limits provided by these rules shall constitute a violation of these rules and shall absolve the employer of financial responsibility for the bill.

(8) Unlisted services or procedures are billable and payable on a by-report (BR) basis as follows:

(a) The fee for the performance of any BR service shall be negotiated between the provider and the payer prior to delivery of the service. Payers should ensure that a CPT® code with an established HCP fee schedule amount is not available.

(b) Performance of any BR service requires that the provider submit a written report, for which no separate charge is allowed, with the billing to the payer. The report shall substantiate the rationale for not using an established CPT® code and shall include pertinent information regarding the nature, extent, and special circumstances requiring the performance of that service and an explanation of the time, effort, personnel, and equipment necessary to provide the service.

(c) Information provided in the medical record(s) may be submitted in lieu of a separate report if that information satisfies the requirements of Paragraph (12) of Subsection C of 11.4.7.8 NMAC.

(d) In the event a dispute arises regarding the reasonableness of the fee for a BR service, the provider shall make a prima facie showing that the fee is reasonable. In that event, the burden of proof shall shift to the payer to show why the proposed fee is not reasonable.

(9) If payer and provider agree to enter into a global fee agreement at any time, a global fee can be used. All services not covered by the global fee agreement shall be coded and paid separately, to the extent substantiated by medical records. Agreement to use a global fee creates a presumption that the HCP will be allowed to continue care throughout the global fee period.

(10) If a service that is ordinarily a component of a larger service is performed alone for a specific purpose it may be considered a separate procedure for coding, billing, and payment purposes. Documentation in the medical records must justify the reasonableness and necessity for providing such services alone.

(11) Initial bills for every visit shall be accompanied by appropriate office notes (medical records) which clearly substantiate the service(s) being billed and are legible.

(12) Records provided by hospitals and FASCs shall have a copy of the admission history and physical examination report and discharge summary, hospital emergency department medical records, imaging, ambulatory surgical center medical records or outpatient surgery records.

(13) No charge shall be made to any party to the claim for the initial copy of required information.

(14) The worker shall not be billed for health care services provided by an authorized HCP as treatment for a valid workers' compensation claim unless payer denies compensability of a claim or payer does not respond to a bill within the time limit set forth in Paragraph (2) of Subsection D of 11.4.7.8 NMAC.

(15) Diagnostic coding shall be consistent with the most current version of the international classification of diseases, clinical modification or diagnostic and statistical manual of mental disorders guidelines required by CMS as appropriate.

(16) For any reimbursement under the HCP fee schedule or these rules that is based upon provider's cost, the provider shall submit a copy of the invoice showing that cost at the time of billing.

(17) The health care facility is required to submit all requested data to the payer. Failure to do so could result in fines and penalties imposed by the WCA. All payers are required to notify the economic research bureau of unreported data fields within 10 days of payment of any inpatient bill.

D. Payment provision ground rules.

(1) The provision of services gives rise to an obligation of the employer to pay for those services. Accordingly, all services are controlled by the rules in effect on the date the services were provided.

(2) For all reasonable and necessary services provided to a worker with a valid workers' compensation claim, payer is responsible for timely good faith payment within 30 days of receipt of a bill for services unless payment is pending in accordance with the criteria for contesting bills and an appropriate explanation of benefits has been issued by the payer. Payment for non-contested portions of any bill shall be timely.

(3) All medical services rendered pursuant to recommended treatment contained in the most recent edition of the official disability guidelines™ (ODG) is presumed reasonable and necessary pursuant to Subsection A of Section 52-1-49 NMSA 1978; there is no presumption regarding any other treatment.

(4) If a service has been pre-authorized or is provided pursuant to a treatment plan that has been pre-authorized by an agent of the payer, it shall be presumed that the service provided was reasonable and necessary. The presumption may be overcome by competent evidence that the payer, in the exercise of due diligence, did not know that the compensability of the claim was in doubt at the time that the authorization was given.

(5) An employer/insurer who subcontracts bill review services remains fully responsible for timely payment of reasonable and necessary services along with compliance with these rules.

(6) Fees and payments for all physician professional services, regardless of where those services are provided, are reimbursed within the HCP fee schedule.

(7) Bills may be paid individually or batched for a combined payment; however, each service, date of service and the amount of payment applicable to each procedure must be appropriately identified.

(8) All bills shall be paid in full unless one or more of the following criteria are met. These criteria are the only permissible reasons for contesting workers' compensation bills submitted by authorized providers:

(a) compensability is denied;

(b) services are deemed not to be reasonable and necessary;

(c) incomplete billing information or support documentation;

(d) inaccurate billing or billing errors; or

(e) reduction specifically authorized by this rule.

(9) Whenever a payer contests a bill or the payment for services is denied, delayed, reduced or otherwise differs from the amount billed, the payer shall issue to the provider a written EOB which shall clearly relate to each payment disposition by procedure and date of service. Only the EOBs listed in the HCP fee schedule may be used.

(10) Failure of the payer to indicate the appropriate EOB(s) constitutes an independent violation of these rules.

(11) The prorating of the provider's fees for time spent providing a service, as documented in the provider's treatment notes, is not prohibited by these rules provided an appropriate EOB is sent to the provider. Evaluation and management CPT® codes shall not be prorated. The provider's fees should not be prorated to exclude time spent in pre- and post-treatment activity, such as equipment setup, cleaning, disassembly, etc.,

if it is directly incidental to the treatment provided and is adequately documented.

(12) A request for reconsideration, including corrected claims, shall be submitted to the payer within 30 days of receipt of the payer's written disposition. Failure to comply with the deadline for a request for reconsideration or for seeking a director's determination as provided below shall result in acceptance of the payer's position.

(13) Payment or disposition of a request for reconsideration shall be issued within 30 days of payer's receipt of the request for reconsideration. Failure to comply with the established deadline shall result in the payer accepting the provider's position asserted in the request for reconsideration.

[11.4.7.8 NMAC - Rp, 11.4.7.8 NMAC, 1/1/2023]

11.4.7.9 FEES FOR HEALTH CARE SERVICES

A. HCP fee schedule.

(1) The director shall issue an order pursuant to Section 52-4-5 NMSA 1978 not less than once per annum setting the HCP fee schedule which shall list the maximum amount of reimbursement for, or the method for determining the maximum amount of reimbursement for medical services, treatments, devices, apparatus, and medicine.

(2) In addition to the HCP fee schedule, the director's HCP fee schedule order shall contain a brief description of the technique used for derivation of the HCP fee schedule and a reasonable identification of the data upon which the HCP fee schedule was based.

(3) The HCP fee schedule is procedure-specific and provider-neutral. Any code listed in the edition of the current procedural terminology adopted in the director's HCP fee schedule order may be used to designate the services rendered by any qualified provider within the parameters set by that provider's licensing regulatory agencies combined with applicable state laws, rules, and regulations.

(4) The HCP fee schedule shall be released to the public not less than 30 days prior to the date upon which it is adopted and public comments will be accepted during the 30 days immediately following release.

(5) After consideration of the public comments the director shall issue a final director's HCP fee schedule order adopting a HCP fee schedule, which shall state the date upon which it is effective. The final director's HCP fee schedule order shall be available at the WCA clerk's office not less than 20 days prior to its effective date.

B. Telehealth and telephonic services.

(1) Both telehealth and telephonic services are allowable for workers' compensation patients

(2) Telehealth and telephonic services shall be reimbursed according to fees set forth in the HCP fee schedule.

C. Hospital reimbursement.

All hospitals shall be reimbursed according to the methodology set forth in the HCP fee schedule and with the director's HCP fee schedule order.

D. Prescription medicine.

(1) The maximum payment that a pharmacy or authorized HCP is allowed to receive for any prescription medicine shall be determined by the method set forth in the HCP fee schedule.

(2) Pharmacies shall not dispense more than a 30 day supply of medication unless authorized by the payer.

(3) Only generic equivalent medications shall be dispensed unless a generic does not exist and unless specifically ordered by the HCP.

(4) Compounded medication shall be paid in accordance with the HCP fee schedule.

(5) Any medications dispensed and administered in excess of a 24 hour supply to a registered emergency room patient shall be paid according to the hospital ratio.

(6) Health care provider dispensed medications shall not exceed a 10 day supply for new prescriptions only. The payment for health care provider dispensed medications shall not exceed the cost of a generic equivalent.

E. Medical cannabis reimbursement.

(1) General Provisions

(a) The maximum payment that a worker may be reimbursed for medical cannabis shall be determined by the method and amount set forth in the HCP fee schedule.

(b) Medical cannabis may be a reasonable and necessary medical treatment only where an authorized health care provider certifies that other treatment methods have failed.

(c) At least one physician certifying worker for participation in the cannabis program shall be an authorized health care provider.

(d) The worker must be an enrolled in the cannabis program and provide proof of enrollment and qualifying condition prior to the date of purchase of medical cannabis to be eligible for reimbursement.

(2) Worker shall be reimbursed upon the following conditions:

(a) Only the worker shall be reimbursed for the out of pocket cost of medical cannabis;

(b) Worker shall submit an itemized receipt issued by a licensed producer that includes the name and address of the licensed producer and the worker, the date of purchase, the quantity in grams of dry weight, the form of medical cannabis purchased, and the purchase price;

(c) Worker shall be reimbursed no more than the maximum amount set forth in the HCP fee schedule;

(d) Reimbursement shall be limited to the quantity set forth in the HCP fee schedule;

(e) Reimbursement for paraphernalia, as defined in the Controlled Substances Act, shall not be made; and

(f) Reimbursement is not allowed for expenses related to personal production or cannabis acquired from sources other than a licensed producer.

F. Referrals.

(1) If a referral is made within the initial 60 day care period as identified by Subsection B of Section 52-1-49 NMSA 1978, the period is not enlarged by the referral.

(2) When referring the care of a patient to another provider, the referring provider shall submit pertinent medical records for that patient, including imaging, upon request of the referral provider, at no charge to the patient, referral provider or payer.

(3) When transferring the care of a patient to another provider, the transferring provider shall submit complete medical records, including imaging, for that patient to the subsequent provider at no charge to the patient, subsequent provider or payer.

G. Independent medical examinations.

(1) All IMEs and their fees must be authorized by the claims payer prior to the IME scheduling and service, regardless of which party initiates the request for an IME.

(2) In the event that an IME is authorized and the HCP and claims payer are unable to agree on a fee for the IME, the judge may set the fee or take other action to resolve the fee dispute.

H. Physical impairment ratings.

(1) All PIRs and their fees shall be authorized by the claims payer prior to their scheduling and performance regardless of which party initiated the request for a PIR. The PIR is inclusive of any evaluation and management code.

(2) Impairment ratings performed for primary and secondary mental impairments shall be billed pursuant to the HCP fee schedule and shall conform to the guidelines, whenever possible, presented in the most current edition of the AMA guides to the evaluation of permanent impairment.

(3) A PIR is frequently performed as an inherent component of an IME. Whenever this occurs, the PIR may not be unbundled from the IME. The HCP may only bill for the IME at the appropriate level.

(4) In the event that a PIR with a specific HCP is ordered by a judge and the HCP and claims payer are unable to agree on a fee for the PIR, the judge may set the fee or take other action to resolve the fee dispute.

[11.4.7.9 NMAC - Rp, 11.4.7.9 NMAC, 1/1/2023]

11.4.7.10 QUALIFICATION OF OUT OF STATE HEALTH CARE PROVIDERS

A. An HCP that is not licensed in the state of New Mexico must be approved by the director to qualify as an HCP under the act.

B. No party shall have recourse to the billing and payment dispute resolution provisions of these rules with respect to the services of an HCP who is not licensed in New Mexico or approved by the director.

C. The director's approval may be obtained by submitting an application to the director and proposed order, supported by an original affidavit of the HCP seeking approval. Nothing in this rule shall prevent the director from entering into agreements with any party or HCP to provide for simplified and expeditious qualification of HCPs in individual cases, provided, however, that all such agreements shall be considered public records.

D. The director's approval of a health care provider in a particular case, pursuant to the provisions of Section 52-4-1 NMSA 1978 will be deemed given when an out of state health care provider provides services to that injured worker and the employer/insurer pays for those services. Unless otherwise provided, the approval obtained by this method will not apply to the provision of health care by that provider to any other worker, except by obtaining separate approval as provided in these rules.

E. The out of state health care provider shall comply with the New Mexico HCP fee schedule, however, nothing in these rules shall preclude the separate negotiation of fees between an out of state provider and a payer within the HCP fee schedule for any health care service as set forth in these rules.

F. In lieu of a formal director's approval, the payer may accept an original Out of State Health Care Provider Affidavit, as provided on the WCA website, from an HCP who is licensed by their state and in good standing.

[11.4.7.10 NMAC - Rp, 11.4.7.10 NMAC, 1/1/2023]

11.4.7.11 BILLING AND PAYMENT DISPUTE RESOLUTION

A. In the event of a billing or payment dispute any party may submit to the medical cost containment bureau a request for director's determination on the approved form located on the WCA website.

B. The request shall be made in writing within 30 days of the documented receipt date of the payer's disposition, nonpayment of the bill, or denial of a request for reconsideration. A request for director's determination shall consist of a brief explanation of the disputed billing and payment issue(s) and shall be accompanied by a copy of the bill(s) in question, a copy of the payer's explanation, and all

supporting documentation necessary to substantiate the performance of the service(s) and the accuracy of the associated charges.

C. Upon receipt of a request, the administration will initially attempt to resolve the dispute informally. If this is unsuccessful, a notice of receipt of request for director's determination shall be filed with WCA clerk of the court and issued to both parties.

D. Both parties shall have 15 days from the date of the notice of receipt of request for director's determination to present to the WCA clerk of the court and opposing party any pertinent responses or appropriately captioned exhibits.

E. Parties who present responses or exhibits shall be responsible for service of such documents to all parties of record.

F. The director in his discretion may conduct such hearings and receive such evidence as is necessary to make a determination concerning the reasonableness and necessity of the services provided. A final determination shall issue within 45 days of the issuance of the notice of receipt of request for director's determination or the close of the hearing, whichever is later.

G. The director's determination of the billing and payment dispute is final. Any further attempt, directly or indirectly, to charge any party for any disallowed services or to fail to pay within 30 days of documented receipt of the director's determination for such services as may have been found to be due and owing shall be considered a violation of this rule.

H. The director's determination shall not be considered with regard to the compensability of the claim and shall have no legal force or effect beyond the resolution of the billing and payment disputes.

I. Any time frame set forth in 11.4.7.11 NMAC may be waived by the director, in writing, for good cause shown.

J. Nothing in this rule shall prohibit the parties from resolving their billing dispute prior to or following referral to the administration.

[11.4.7.11 NMAC - Rp, 11.4.7.11 NMAC, 1/1/2023]

11.4.7.12 INPATIENT ADMISSIONS, CASE MANAGEMENT AND UTILIZATION REVIEW:

A. Basic provisions.

(1) All workers and their legal representatives are required to cooperate with the WCA or its contractor, if any, with respect to all reasonable requests for information necessary for any provision of service.

(2) For the purpose of facilitating the provision of services, all employers, insurers, and third party administrators are required to communicate, cooperate and provide information, without charge, to the WCA or its contractor, if any.

(3) The WCA or its contractor, if any, shall report any refusal to cooperate to the director. Failure to provide requested information shall be presumed to be a refusal to cooperate. Any dispute concerning the reasonableness of any request for information may be submitted, in writing, to the director. The determinations of the director concerning the reasonableness of such requests are final.

(4) In any hearing before the WCA, the worker's refusal to cooperate in any services may be considered by a workers' compensation judge on the issues of reasonableness and necessity of medical charges or reasonableness, necessity, or appropriateness of medical treatment.

(5) The contractor shall avoid conflicts of interest or the appearance of impropriety when performing case management services and utilization review.

(6) Nothing in these rules prohibits an employer from establishing their own system of case management or utilization review at the employer's expense as provided in Section 52-4-3 NMSA 1978.

B. Inpatient admission review

(1) For every inpatient admission the following information shall be provided to the WCA or its contractor at least 48 hours prior to the admission or before the close of the next business day after any emergency admission:

(a) worker's/patient's name;

(b) worker's/patient's social security number;

(c) worker's/patient's employer;

(d) employer's insurance carrier or third party administrator and a statement of whether they have authorized the admission;

(e) date of injury/onset of symptoms;

(f) admitting diagnosis, including primary, secondary, and tertiary, if any;

(g) planned treatment(s) and procedures;

(h) planned date of admission; and

(i) proposed length of stay.

(2) For planned or elective hospital admissions any practitioner ordering the admission of a worker for evaluation or treatment of their injury or occupational disease disablement shall report the admission to the WCA.

(3) For emergency hospital admissions, the hospital shall report the admission to the WCA.

C. Case management

(1) Referral process:

(a) Any party may refer a claim to the WCA for case management by the WCA or its contractor, if any, by submitting the appropriate form to the WCA medical cost containment bureau. The form is located on the agency website.

(b) A WCA judge may refer a claim for

case management by submitting a written referral to the medical cost containment bureau and with a copy placed in the court file.

(c) Within 20 days of receiving a referral and all supporting documentation, the medical cost containment bureau shall notify the parties and the judge, if any, of its decision either accepting or denying the referral. The medical cost containment bureau may assign approved cases to the WCA's contractor.

(d) Any party who objects to the decision of the medical cost containment bureau shall notify the WCA of its objection by filing an application to the director not later than 15 days from service of the decision.

(2) Procedures:

(a) The WCA will consider the following factors when determining eligibility of a case referred for case management:

(i) severe or complex injury including total loss of limb/amputation, severe injury to multiple body parts or limbs, severe burns over a large part of body, traumatic brain injury, spinal cord injury, reflex sympathetic dystrophy/ complex region pain syndrome;

(ii) language barrier, including hearing impairment;

(iii) a record or pattern of non-compliance with prescribed treatment, care plan or medical appointments;

(iv) multiple health care providers, including providers of different disciplines, requiring coordination between them;

(v) inpatient admission lasting longer than five days or multiple admissions or emergency room visits;

(vi) failure to reach maximum medical improvement after one year from the date of injury;

(vii) psychological issues that complicate provision of services; and

(viii) any other reasonable criteria as approved by the director.

(b) The WCA will monitor case management services to ensure progress pursuant to Section 52-4-3 NMSA 1978. The WCA may terminate or reassign services as it deems appropriate with notice to the parties.

(c) The contractor shall have the right to contact the worker, insurer, third party administrator, legal representatives, and all HCPs involved in the case. The contractor shall give reasonable notice and an opportunity to the worker or his or her representative to be present during, or to participate in, any and all contacts by the case manager.

(d) The contractor providing case management services may help coordinate services by bringing treatment options or return to work opportunities to the attention of the health care provider.

(e) The contractor shall provide status reports to the WCA as directed, with copies to the parties identified in the initial assignment.

D. Utilization review

(1) Referral process:

(a) Any party may refer a claim to the WCA for utilization review by the WCA or its contractor, if any, by submitting the appropriate form to the WCA medical cost containment bureau. The form is located on the agency website.

(b) A utilization review request for pre-admission review of hospital admissions, except for emergency services, shall also follow this same referral and procedural process.

(c) Within 20 days of receiving a referral and all supporting documentation, the medical cost containment bureau shall notify the parties of its decision either accepting or denying the referral. The medical cost containment bureau may assign approved cases to the WCA's contractor.

(d) Any party who objects to the decision of the medical cost containment bureau shall notify the WCA of its objection by filing an application to the director not later than 15 days from service of the decision.

(2) Procedures:

(a) Utilization review shall consider only the medical reasonableness, clinical necessity, efficiency and quality of the treatment under review.

(b) Only one treatment is appropriate for utilization review.

(c) Utilization review shall not include issues of compensability, including:

(i) the causal relationship between the treatment under review and the worker's work-related injury;

(ii) whether the worker is disabled; and

(iii) whether the worker is at maximum medical improvement.

(d) If the medical cost containment bureau or its contractor requests additional information, the parties shall provide the requested information within 15 days. The WCA shall issue its utilization review decision within 60 days of receiving all necessary documentation.

(e) The WCA in its sole discretion may assign a claim to its contractor for peer review. Peer review shall only be conducted by a licensed healthcare provider who is in a similar field or equivalent discipline as the provider whose service is being reviewed. Peer review shall be independent and the physician or health care provider should not have prior involvement in the worker's care or treatment.

(f) The medical cost containment bureau shall communicate the utilization review findings in writing with a copy to all parties. The WCA may adopt the findings of its contractor after utilization review.

(g) Any party who objects to the utilization review findings shall file an application to director within 15 days from service of the utilization review findings. If an application is not filed within 15 days, the utilization review findings shall become binding on the parties.

(h) The director may set a utilization review matter for hearing. An order issued by the director after hearing or receipt of an application to director is final and binding on the parties.
[11.4.7.12 NMAC - Rp, 11.4.7.12 NMAC, 1/1/2023]

11.4.7.13 NON-CLINICAL SERVICES

A. For medical records and report copies requested for the purpose of investigating or administering a workers' compensation claim, a practitioner may charge for paper and electronic copies as set forth in the HCP fee schedule, except as provided in Paragraphs (12), (13), (14) and (15) of Subsection C of 11.4.7.8 NMAC. This fee is inclusive of any and all fees, including, but not limited to, administrative, processing, and handling fee of any kind.

B. A practitioner may charge for the completion of the WCA Form Letter to Health Care Provider the amount set forth in the HCP fee schedule.

C. A practitioner may charge for the completion of the WCA Provider's Report of Physical Ability according to the criteria and amount set forth in the HCP fee schedule.

D. Depositions

(1) An HCP may not charge more than $400 for the first hour or any portion thereof; and not more than $360 per hour for the second and subsequent hours, prorated in five minute increments. An HCP may not charge more than $200 for the first hour of deposition preparation time actually spent, and not more than $120 per hour for the second or third hours, prorated in five minute increments, up to a maximum of three hours.

(2) No compensation shall be paid for travel time to or from the deposition, waiting time prior to the scheduled beginning of the deposition, or time spent reading or correcting depositions. For good cause shown, a judge may enter a written order providing recompense to an HCP for reading and correcting a deposition.

(3) An HCP may require that they be paid for the first hour of the deposition testimony either before or at the time of the deposition.

(4) A non-refundable fee of up to $400 may be charged by an HCP for deposition appointments at which the attorney making the appointment is a no-show or fails to cancel at least 48 hours in advance.

(5) Any notice of deposition to a practitioner shall contain the following language: "The rules of the WCA provide a schedule of maximum permissible fees for deposition testimony. No more than $400 for the first hour and $360 for each subsequent hour is permitted. Fees for the second and subsequent hours shall be prorated in five minute increments. An HCP may not charge more than $200 for the first hour of deposition preparation time actually spent, and not more than $120 for the second or third hours, prorated in five minute increments, up to a maximum of three hours."

E. Live testimony by a health care provider: Such testimony is allowed only pursuant to an order by a judge. Fees for live testimony, travel, lodging, and preparation time shall be set by the judge.

F. Disputes concerning the HCP fee schedule shall be raised with the assigned judge, if any, or pursuant to the medical billing dispute process set forth in 11.4.7.11 NMAC.
[11.4.7.13 NMAC - Rp, 11.4.7.13 NMAC, 1/1/2023]

11.4.7.14 ENFORCEMENT: Any complaint of a violation of these rules shall be made, in writing, to the medical cost containment bureau, enforcement bureau, or assigned workers' compensation judge, if any.
[11.4.7.14 NMAC - Rp, 11.4.7.15 NMAC, 12/31/2013; A, 10/1/2015, Rp, 1/1/2023]

11.4.7.15 DATA ACQUISITION:

A. The insurer must report an inpatient hospital bill to the WCA within 10 to 90 days of payment of the bill. Reports may be submitted by mail, fax, or electronic media in batches daily, weekly, or monthly from the insurer or insurer's representative.

B. The paid inpatient services data shall be submitted in a format acceptable to the WCA. The economic research bureau shall distribute a specific set of instructions for the submission of required data. If the required paid inpatient services data is not received from payer as stated under Subsection A of this section, the economic research bureau may petition for a hearing before the WCA director and seek penalties pursuant to Section 52-1-61 NMSA 1978.
[11.4.7.15 NMAC - Rp, 11.4.7.16 NMAC, 1/1/2023]

11.4.7.16 RETURN-TO-WORK: The agency website shall contain educational Return-To-Work best practice tools and resources for workers' compensation stakeholders.
[11.4.7.16 NMAC – N, 1/1/2023]

HISTORY OF 11.4.7 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center.
WCD 90-1, Nonprofessional Fees Schedule, filed 10/15/90.
WCA 91-6, Nonprofessional Fees Schedule, filed 5/29/91.
WCA 92.6, Rules Governing Fees for Non-Clinical Services, filed 10/30/92.
WCA 91-7, Hospital Fee Schedule, filed 4/1/91.
WCA 91-7, Hospital Fee Schedule, filed 7/15/91.
WCA 92.7, Rules Governing Hospital and Ambulatory Surgical Center Fees, filed 10/30/92.

WCA 93.7, Rules Governing Hospital Inpatient Stays, Outpatient Surgeries, Emergency Department Visits and Ambulatory Surgical Center Fees, filed 3/3/94.
WCA 92-8, Workers' Compensation Administration Rules Governing Utilization Review, Peer Review and Case Management, filed 2/24/92.
WCA 92.8, Rules Governing Utilization Review, Peer Review and Case Management, filed 10/30/92.
WCA 93-8, Rules Governing Utilization Review, Peer Review and Case Management, filed 10/28/93.
WCD 91-9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 12/30/91.
WCA 92.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 11/18/92.
WCA 92.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 12/21/92.
WCA 93.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 2/23/94.
WCA 95.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 11/18/94.
WCA 95.9, Rules Governing the Schedule of Maximum Allowable Payments for Health Care Services, filed 1/17/95.

History of Repealed Material:
11.4.7 NMAC, Payments for Health Care Services, filed 12/15/2011 - Repealed effective 12/31/2013.
11.4.7 NMAC, Payments for Health Care Services, filed 12/13/2022 - Repealed effective 1/1/2023.

WORKERS COMPENSATION ADMINISTRATION

This is an amendment to 11.4.1 NMAC, Sections 7, and 8, effective 1/1/2023.
Statutory citations were changed throughout the rule, and in Section 3, in order to conform to correct legislative style.

11.4.1.7 DEFINITIONS: The definitions adopted below shall apply to all WCA rules unless expressly indicated otherwise in a specific part of these rules.

A. "Act" means collectively: the Workers' Compensation Act, the Workers' Compensation Administration Act, [~~the Subsequent Injury Act,~~] and the Occupational Disease Disablement Law, Sections 52-4-1 to 52-4-5 NMSA 1978 [~~(Repl. Pamp. 1991)~~]. This definition includes prior law applicable to the particular facts of the claim.

B. "Administration" means the workers' compensation administration (WCA).

C. "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.

D. "Cause" means any and all proceedings before the WCA pertaining to the same disease or accidental injury and assigned the same file number by the clerk of the administrative court.

E. "Claim" means any allegation of entitlement to benefits or relief under the act, which has been communicated to the employer by the giving of notice as required by the act.

F. "Clerk" (also referred to as clerk of the administrative court or clerk of the WCA) means any individual assigned by the director to oversee the filing of claims and records with the WCA.

G. "Complaint" means a written request for workers' compensation benefits or any relief under the Act, filed on a mandatory form with the clerk of the WCA by a worker, employer, insurance carrier or the uninsured employers' fund.

H. "Director" means the director of the WCA.

I. "Employer" means, collectively, unless otherwise stated: an employer subject to the act; a self-insured entity, group or pool; a workers' compensation insurance carrier or its representative; or any authorized agent of an employer or insurance carrier, including any individual owner, chief executive officer or proprietor of any entity employing workers.

J. "Health care provider" (also referred to in the rules as "HCP") means any person, entity or facility authorized to furnish health care to an injured worker pursuant to Section 52-4-1 NMSA 1978 [~~(Repl. Pamp. 1991)~~], including any provider designated pursuant to Sections 52-1-49 or -51 NMSA 1978 [~~(Repl. Pamp. 1991)~~] and may include a provider licensed in another state if approved by the director, as required by the act.

K. "IME", or independent medical examination, means a medical examination of a worker, by a provider other than a previously designated health care provider, upon whom the parties have agreed or the judge has appointed according to the act.

L. "Judge" means a workers' compensation judge appointed by the director pursuant to Section 52-5-2 NMSA 1978 [~~(Repl. Pamp. 1991)~~].

M. "Mediation conference" means a mandatory conference at which all parties named in the complaint shall appear and present their positions to the mediator.

N. "Mediator" means a director's designee, who will evaluate and attempt to resolve a complaint by holding a mediation conference and issuing a recommendation for resolution of the complaint.

O. "Medical records" means:

(1) all records, reports, letters, and bills produced or prepared by a HCP relating to the care and treatment rendered the worker;

(2) all other documents generally kept by the HCP in the normal course of business relating to the worker, including, but not limited to, clinical, nurses' and intake notes, notes evidencing the patient's history of injury, subjective

and objective complaints, diagnosis, prognosis and/or restrictions, reports of diagnostic testing, hospital records, logs and bills, physical therapy records and bills for services rendered.

P. "Party" may include any of the following:

(1) an employer against whom a claim has been asserted by an injured or disabled worker;

(2) an injured or disabled worker asserting a claim against an employer;

(3) the uninsured employers' fund, if a claim has been asserted against it;

(4) a health care provider named in a billing dispute or seeking qualification as an out-of-state provider; or

(5) any other person or entity named in an administrative enforcement proceeding.

Q. "Pending cause" means any cause in which a party has filed a document with the clerk of the WCA within the previous six months, and which has not yet been administratively closed by the clerk.

R. "Person" means any individual, association, organization, reciprocal or Lloyd's plan insurer, partnership, firm, syndicate, trust, corporation and every legal entity as defined in Section 59A-1-10 NMSA 1978 [~~(Repl. Pamp. 1991)~~].

S. "Pleading" means any document filed and endorsed by the clerk.

T. "Rules of civil procedure" means the Rules of Civil Procedure for the district courts, as adopted by the supreme court of New Mexico.

U. "Rules of evidence" means the Rules of Evidence as adopted by the supreme court of New Mexico.

V. "Rules of the WCA" means rules enacted by the WCA and cited as 11.4 NMAC.

(1) These rules are organized by title, chapter, part, section, paragraph and subparagraph.

(2) For ease of use, these rules may be referred to in writing and speech by part, section, paragraph and subparagraph.

W. "Unfair claims processing" means any practice, whether intentional or not, which unreasonably delays or prolongs the payment of benefits at a rate not consistent with the act. "Unfair claims processing" is a less severe violation than "bad faith" and includes, but is not limited to, any and all of the following practices with respect to claims, by an employer, insurer, third party administrator, worker or other person:

(1) knowingly misrepresenting pertinent facts relating to workers' compensation benefits or failing to disclose facts material to a workers' compensation claim;

(2) failing to acknowledge and act promptly upon communications with respect to claims;

(3) failing to adopt and implement reasonable standards for the prompt investigation and processing of claims;

(4) failing to affirm or deny coverage of claims within a reasonable time after a request for payment of benefits has been submitted to an employer;

(5) not attempting in good faith to develop prompt, fair and equitable settlements of claims in which liability has become clear;

(6) compelling litigation to recover amounts due by offering substantially less than the amounts ultimately recovered in actions brought by similarly situated workers;

(7) initiating litigation when benefits are currently being paid at the maximum rate of entitlement under the act;

(8) soliciting, accepting or obtaining a complete release of liability in exchange for an acceleration of benefits, or discounting an acceleration of benefits, where such an acceleration is not made pursuant to a lump sum payment approved by a judge; and

(9) failing to timely pay authorized and undisputed medical bills.

X. "Wage records" means all records evidencing all wages, commissions, overtime pay, gratuities, meals, board, rent, housing or lodging received from any employer during all time periods relevant to the act.

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

[11.4.1.7 NMAC - Rp, 11 NMAC 4.1.7, 10/1/2014; A, 1/1/2023]

11.4.1.8 CONFIDENTIALITY:

A. All records of the WCA are confidential except:

(1) as provided in Section 52-5-21 NMSA 1978;

(2) records required to be released by order of a court of competent jurisdiction;

(3) the identity of the insurance carrier for a particular employer, the fact that the employer is certified as a self-insurer or the fact that the administration has no record of compliance with the insurance requirement of the Act;

(4) any matter required to be made available to another state agency pursuant to statutes, joint powers agreements or memoranda of understanding; or

(5) as otherwise provided by law.

B. Procedure for requesting access to WCA records (both public and confidential records):

(1) Inspection of records will be allowed only during normal business hours.

(2) A written request to inspect must be submitted to the [~~clerk~~] records custodian. The written request to inspect shall indicate sufficient information to distinctively identify and retrieve the [~~file~~] records to be inspected.

(3) The WCA shall charge a reasonable fee for copies of records, the amount of which shall be posted at the clerk's office and on the WCA website.

C. Right to inspect confidential WCA records:

(1) Once a disablement or accident occurs, any person who is a party to a claim arising from the disablement or accident shall have the right to inspect all files relating to the accident or disablement, and all files relating to any prior accident, injury or disablement of the worker.

(2) The named party, representative or the attorney in a claim shall be required to provide acceptable proof of identity prior to being allowed to inspect confidential WCA records. Acceptable proof of identity shall be a driver's license or other identification bearing a photograph, name and address of the person requesting inspection. An attorney or other representative requesting confidential records on behalf of a party must show proof of the principal-agent relationship through a filed entry of appearance, a signed release or waiver, a signed power of attorney, written correspondence on law firm letterhead or through other reliable means.

(3) The [~~clerk~~] records custodian shall review the written request and determine if the person requesting the inspection has a right to inspect confidential WCA records.

(4) The clerk shall allow only authorized employees of the WCA, or parties to a claim, including their attorneys or other representatives, access to confidential WCA records.

[11.4.1.8 NMAC - Rp, 11 NMAC 4.1.8, 10/1/2014; A, 1/1/2023]

WORKERS COMPENSATION ADMINISTRATION

This is an amendment to 11.4.5 NMAC, Sections 10, 11, 12, 13 and 15, effective 1/1/2023.
Statutory citations were changed throughout the rule, and in Section 3, in order to conform to correct legislative style.

11.4.5.10 ENFORCEMENT OF THE ACT BY THE DIRECTOR:

A. These rules establish a procedure for the administrative enforcement of the act by the director. These rules do not govern procedure for criminal prosecution by the WCA's enforcement bureau.

B. Administrative enforcement proceedings shall be presided over by the director or designee and shall be conducted with dignity, in a manner conducive to deliberation.

C. Administrative enforcement hearings shall be recorded by a certified court monitor in compliance with the rules governing the recording of judicial proceedings adopted by the New Mexico supreme court.

D. No right of peremptory disqualification: The peremptory right of disqualification does not apply to proceedings conducted under the provisions of this rule.

E. The rules of civil procedure [~~and evidence~~] shall apply where not inconsistent with the provisions of these rules. The rules of evidence shall not apply. The rules of privilege shall apply to the extent that they are required to be recognized in civil actions in the district courts of New Mexico.

[11.4.5.10 NMAC - Rp, 11 NMAC 4.5.10, 10/1/2014; A, 1/1/2023]

11.4.5.11 INITIATION OF ADMINISTRATIVE ENFORCEMENT PROCEEDINGS:

A. Commencement of action:

(1) An action may be commenced by the issuance of a notice of administrative enforcement proceeding by the enforcement bureau chief. The notice shall be delivered immediately to the director.

(2) The notice of administrative enforcement proceeding shall be in the form of a signed statement containing the name, address and phone number of the violator, a statement of facts, the specific violation charged and the specific rule or statutory provision violated.

B. Probable cause determination:

(1) A probable cause determination shall be made by the director in each case where a notice of administrative enforcement proceeding has been issued. The probable cause determination shall be made promptly, but in any event within 30 days after the service of the notice.

(2) The director may make the determination of probable cause solely upon a paper review of the administrative file. [~~The director may consider hearsay evidence from a credible source with a factual foundation.~~]

(3) If the director determines no probable cause exists to believe a violation has been committed, the proceeding shall be dismissed and the notice of administrative enforcement shall not be filed with the clerk or served on any party.

(4) If the director determines probable cause exists, a finding of probable cause and a notice of proposed penalty indicating the maximum penalty shall be filed with the clerk along with the notice of administrative enforcement proceedings.

C. When the alleged violator is a party to a pending workers' compensation complaint and the director deems the alleged violations material to the issues raised in the pending complaint, the director shall file the finding of probable cause and notice of proposed penalty and the notice of administrative enforcement proceeding in the case file for the pending complaint and the enforcement proceedings shall be referred to the assigned workers' compensation judge for determination.

[11.4.5.11 NMAC - Rp, 11 NMAC 4.5.11, 10/1/2014; A, 1/1/2023]

11.4.5.12 ADMINISTRATIVE ENFORCEMENT PROCEEDINGS BEFORE THE DIRECTOR: For every case not referred to a workers' compensation judge and upon the filing of the notice of administrative enforcement proceedings and finding of probable cause:

A. Summons: A summons shall be issued by the clerk, directed to the alleged violator and must contain:

(1) The name and street address of the WCA, the docket number of the case and the name of the person(s) or entity the summons is directed to;

(2) A direction that the alleged violator shall appear [~~in person~~] before the director or director's designee in the manner prescribed by the summons, to respond to the charges [~~and the time and place of the hearing~~];

(3) the time and place of the hearing, including video conference and telephone information if appropriate;

[~~(3)~~] (4) A notice that unless the alleged violator appears as directed, the maximum proposed penalty may be imposed; and

[**~~(4)~~**] **(5)** The name, address, telephone number and e-mail address of the prosecuting attorney for the enforcement bureau.

B. Service of the summons:

(1) The summons shall be served [~~by the enforcement bureau by certified mail, domestic return receipt requested, or~~] by any [~~other~~] means [~~;~~] listed in Rule 1-004 NMR Civ. P. Dist. Ct. unless the director orders service [~~in person~~] by other manner reasonably calculated to apprise the alleged violator of the existence and pendency of the action.

(2) Service of the summons shall be completed no less than 15 days before the date the alleged violator is scheduled to appear for a hearing on the violation.

(3) The summons shall be served with endorsed copies of the notice of administrative enforcement proceeding and the director's finding of probable cause and notice of proposed penalty.

C. Service of papers:

(1) Unless the director orders otherwise, every pleading subsequent to the service of the summons shall be served on the violator and filed with the clerk.

(2) When a party is represented by an attorney, service shall be made upon the attorney.

(3) Service shall be made either by mailing a copy by first class mail with proper postage or by handing a copy to the attorney or to the party, unless the director orders service by other means.

[11.4.5.12 NMAC - Rp, 11 NMAC 4.5.12, 10/1/2014; A, 1/1/2023]

11.4.5.13 MOTIONS AND DISCOVERY:

A. Unless otherwise stated in Part 5 or approved by the director, motion practice shall not be allowed in administrative enforcement proceedings.

B. The use of discovery is discouraged. Discovery may be approved only by the director or the director's designee, in exceptional circumstances where justice demands.

[11.4.5.13 NMAC - Rp, 11 NMAC 4.5.15, 10/1/2014; A, 1/1/2023]

11.4.5.15 HEARING:

A. [~~Evidence shall be admitted in accordance with the rules of evidence.~~] The hearing shall be conducted expeditiously, but each party shall be permitted to present their position amply and fairly. The director may admit any documentary evidence, including hearsay evidence, provided that the evidence is relevant, has sufficient indicia of reliability and authenticity, and will assist the director in determining a fact or issue in dispute.

B. The parties shall have the right to call and cross examine witnesses. Oath of witnesses shall be administered by the director.

C. Following the hearing, the director may orally announce the decision and enter the appropriate order.

D. The director may delay issuing the decision for a period not exceeding 60 days if findings of facts and conclusions of law or briefs are to be submitted.

[11.4.5.15 NMAC - Rp, 11 NMAC 4.5.17, 10/1/2014; A, 1/1/2023]

HISTORY OF 11.4.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

WCA 86-3, Evidentiary Rules, filed 5/26/1987.

WCA 89-3, Evidentiary Rules, filed 6/20/1989.

WCA 92.4, Evidentiary Rules, filed 10/30/1992.

WCA 91-1, Miscellaneous Proceedings and Preliminary Questions of Fact, filed 1/24/1991.

WCA 91-1, Miscellaneous Proceedings and Preliminary Questions of Fact, filed 5/29/1991.

WCA 92.1, Rules Governing Miscellaneous Proceedings and Preliminary Questions of Fact, filed 10/30/1992.

WCA 93-1, Rules Governing Miscellaneous Proceedings and Preliminary Questions of Fact, filed 10/28/1993.

History of Repealed Material:

11 NMAC 4.5, Enforcement and Administrative Investigations, filed 5/20/1996, Recompiled 11/30/2001, Repealed effective 10/1/2014.

WORKERS COMPENSATION ADMINISTRATION

This is an amendment to 11.4.6 NMAC, Section 8, effective 1/1/2023.

11.4.6.8 JUDICIAL SELECTION:

A. The director may review the performance of workers' compensation judges at least once

each year in a manner determined by the director.

B. The director shall announce the expiration of the term of a current workers' compensation judge not later than 120 days prior to the expiration of that term. Any incumbent seeking reappointment must apply to the director by filing an application for reappointment not later than [~~105~~] 110 days prior to the expiration of the term to which the incumbent was appointed.

C. After the director receives the application from the incumbent, the workers' compensation administration shall issue a request for public comment regarding the incumbent on its website, and by email solicitation from the WCA public information officer the workers' compensation community. Public comment shall be directed to the WCA general counsel office. The public comment period shall be open for two weeks.

D. Information relating to the incumbent that is obtained pursuant to these rules shall not be a public record under the inspection of public records act.

E. After the public comment period has ended, the general counsel office shall compile the information gathered from the public and provide it to the director without identifying information regarding the person or entity that provided the comment. All public comments will not be provided to the candidate, or if they are shared, that any identifying information will be redacted to protect the identity of the commentator.

[~~**C.**~~] **F.** The director shall review the public comment and the performance of each current judge on the 90th day prior to the expiration of each judge's term, or the closest business day thereto. The director shall consider any relevant factor including, but not limited to the performance of an incumbent judge, public comment regarding the incumbent judge, the continuing and projected need for judicial staffing and any factor that may be considered by the New Mexico judicial nominations commission for the district court in making a decision regarding reappointment.

[~~**D**~~] **G.** Upon announcement of a judicial vacancy by the director, any candidate seeking appointment to the vacancy shall submit an application to the director in a standard format prepared by the director.

(1) All such applications shall be considered public records, not a record of the WCA for the purposes of Section 52-5-21 NMSA 1978 (1991).

(2) The director shall consider any relevant factor including, but not limited to the performance of a judicial candidate before the WCA, the continuing and projected need for judicial staffing and any factor that may be considered by the New Mexico judicial nominations commission for the district court in making a decision concerning appointment.

[~~**E.**~~] **H.** Notwithstanding the above, the director may appoint judges pro tempore when necessary for the efficient and orderly disposition of workers' compensation claims.

[11.4.6.8 NMAC - Rp, 11 NMAC 4.6.8, 12/31/2013; A, 1/1/2023]

WORKERS COMPENSATION ADMINISTRATION

This is an amendment to 11.4.12 NMAC, Sections 7, 8, 9, 11 and 12, effective 1/1/2023.

11.4.12.7 DEFINITIONS:

A. "Claim" means any allegation of entitlement to benefits under Chapter 258, Laws of 2003, which has been communicated to the uninsured employer's fund or to the fund through the workers' compensation administration.

B. "Eligible" and **"eligibility"** mean that the claim is properly subject to payment by the fund to the extent that the claim is compensable. The compensability determination is independent of the eligibility determination. Eligibility and compensability shall be determined in accordance with applicable law.

C. "Fund" means the uninsured employers' fund established by Chapter 258, Laws of 2003 as administered by the workers' compensation administration.

D. "Fund administrator" means a designee of the director charged with administering the fund and implementing the provisions of this rule.

E. "TRD" means the New Mexico taxation and revenue department.

F. "UEF in-house counsel" means lawyers who are employees of the workers' compensation administration who litigate claims on their merits on behalf of the fund and who pursue reimbursement from uninsured employers after the UEF has paid benefits to or on behalf of the worker.

G. "WCA" means the workers' compensation administration of the state of New Mexico.

[11.4.12.7 NMAC - N, 10/15/2003; A, 11/15/2004; A, 12/31/2011, A, 1/1/2023]

11.4.12.8 PROCEDURES FOR SUBMISSION OF CLAIMS:

A. All claims shall be submitted on [~~a~~] the mandatory complaint form available on the WCA website for workers' compensation benefits naming the uninsured employers' fund. [~~The complaint shall contain the name, social security number, telephone number and address of the injured worker, the name, address, and telephone number of the employer for whom the worker was working when the worker was injured or became ill and the date of injury or onset of occupational illness. It shall be the duty of the worker to keep the WCA clerk of the court informed at all times of any changes to worker's address and telephone number.~~]

(1) The date of presentation to the fund shall be deemed to be the earliest date shown on the claim or complaint by an official WCA date stamp.

(2) If a claim is presented to the fund administrator prior to the running of the statute of limitations, the date of presentation shall toll the statute of limitations for purposes of filing against the fund.

B. Eligibility for benefits.

[~~**(1)** The initial determination of worker's eligibility for benefits and the compensability of the claim shall be made at the mediation conference required by Section 52-5-5 NMSA 1978.~~

~~**(2)**~~**]** **(1)** Only those claims for injuries or illnesses that arose from accidents or exposures occurring in New Mexico and on or after June 22, 2003, shall be eligible to make claims against the fund.

[~~**(3)**~~**]** **(2)** Only claims that would have been subject to the terms of the Workers' Compensation Act or Occupational Disease Disablement Law at the time of the injury or exposure shall be eligible to make claims against the fund.

[~~**(4)**~~**]** **(3)** Only claims by workers employed by those employers who, despite the obligation to do so, were not insured pursuant to the Workers' Compensation Act shall be eligible to make claims against the fund.

[~~**(5)**~~**]** **(4)** A worker shall not be eligible to make a claim against the fund if the worker has filed a valid election pursuant to Section 52-1-7 NMSA 1978.

[~~**(6)**~~**]** **(5)** No claim that is eligible for payment by an insurer's guaranty fund, a self-insurer's guaranty fund, or pursuant to the joint and several liability provisions contained in the by-laws or other authorizing documents of a certified group self-insurer shall be eligible to make claims against the fund unless that source of payments is demonstrated by the worker to be insolvent and unable to assume the claim.

[~~**(7)**~~**]** **(6)** A final district court determination that the employer of a worker making the claim was not insured at the time of the worker's injury or occupational illness shall be conclusive with respect to the issue of insurance coverage only. In such cases, all other eligibility issues are reserved for the fund.

C. If a mediator or WCJ determines that it is more likely than not that a complaint before them presents a claim that is eligible for payment by the uninsured employers' fund, the mediator or WCJ shall amend the caption of the complaint to name the fund as a party. Any complaint amended pursuant to this provision shall be forthwith returned to the WCA clerk for further processing pursuant to the provisions of Section 52-5-5 NMSA 1978, notwithstanding the provisions of any other rule.

[11.4.12.8 NMAC - N, 10/15/2003; A, 11/15/2004; A/E, 4/1/2008; A, 12/31/2011; A, 1/1/2023]

11.4.12.9 CLAIMS ADMINISTRATION:

A. The WCA may contract with a an independent adjusting company for the adjusting of those claims that are determined to be eligible for payment by the fund, purchase a loss portfolio transfer covering some or all of the liabilities of the fund, or may purchase a policy of commercial insurance to cover the liabilities of the fund upon a finding by the director that such purchases are in the best interests of the workers eligible to receive benefits from the fund and the entities paying assessment to support the fund.

(1) The fund, in conjunction with the independent adjusting company, if any, shall pay, or oppose, claims on their merits, and shall be treated for purposes of mediation and adjudication of disputes as a party with all rights and responsibilities applicable under law.

(2) With approval of the director, the independent adjusting company may engage outside counsel for representation when necessary.

(3) The fund or the independent adjusting company may solicit information concerning the average weekly wage of the [~~claimant~~] worker from the employer. Provision of such information to the fund or the independent adjusting company shall not constitute an admission that the [~~claimant~~] worker was an employee. In the event that the employer does not respond to the request for wage information, the employer will be informed, in writing, at the last known address of the employer, or by any means authorized by the director or his designee, that wages are in dispute and that the [~~employee's~~] worker's evidence concerning wages shall be used to calculate average weekly wage. In the event that the employer does not respond within a reasonable time from the date the letter described in this paragraph, an affidavit from the worker concerning the wages earned while employed by the uninsured employer shall be deemed sufficient evidence upon which to pay benefits. Any suspected fraudulent reporting of wages by any party shall be reported to the enforcement bureau for investigation.

(4) In the event of a dispute concerning the wage basis for benefits, or in the event of other disputed benefits, the fund and the independent adjusting company [~~are authorized to~~] may pay indemnity or other benefits, under reservation of rights, to the worker based upon available wage or other claim information.

B. With respect to any complaint filed with the WCA arising from a dispute about the provision of any benefit due on any claim eligible for payment by the fund, the fund and the employer at the time of injury or last injurious exposure shall be named as parties.

C. The independent adjusting company shall regularly report to the WCA on expenditures made to and on behalf of workers from the fund.

(1) The independent adjusting company shall file the first report of injury or illness (E1.2) with the WCA within 10 days of the eligibility determination and provide a copy of the E1.2 to the worker.

(2) The independent adjusting company shall file all payment reports required by law.

(3) The independent adjusting company shall maintain records sufficient to allow the WCA director or his designee to audit the administration of claims and shall provide those records upon request to the WCA. The independent adjusting company shall be subject to audit by the WCA or its contractor with respect to the administration of claims against the fund.

(4) The independent adjusting company shall actively support the WCA in its efforts to provide information to the public concerning the fund and to prosecute penalty collection proceedings against an uninsured employer pursuant to this rule.

D. The fund shall have the right to subrogation [~~that would otherwise be available to the payer~~] as provided by Section 52-1-9.1 NMSA 1978.

(1) The independent adjusting company may pursue subrogation rights on behalf of, and at the direction of, the fund.

(2) The independent adjusting company shall be entitled to retain reimbursement for reasonable legal fees and expenses plus ten percent of the sum recovered in subrogation net of legal fees and expenses. The remainder of the subrogation recovery shall be paid to the fund.

E. The fund shall be liable only for those benefits that are due under the Workers' Compensation Act or Occupational Disease Disablement Law.

(1) The fund shall be entitled to the protections of the exclusive remedy provisions of the Workers' Compensation Act or Occupational Disease Disablement Law to the same extent it would if it were the insured employer of any worker who is eligible for benefits against the fund.

(2) The fund shall not be subject to claims for payments of a judgment obtained in a third party lawsuit, nor for payment of a judgment obtained in a tort action against an uninsured employer.

F. Duplicate recovery of workers' compensation benefits is strictly prohibited.

(1) The fund shall immediately cease payments to or on behalf of any worker who is receiving workers' compensation payments from another source for the same injury and arising out of the same accident.

(2) The fund shall have the right of first reimbursement for workers' compensation benefit payments made that duplicate any payments received by the injured worker from another source and may offset subsequent payments, institute collection proceedings, request criminal investigation or seek any other lawful remedy to recover duplicate payments of workers' compensation benefits.

G. Payments under the fund shall not constitute payments by the employer for purposes of the exclusive remedy provisions of the Act. The fund shall be entitled to assert all defenses and subrogation rights that would be available to an insured employer.

[11.4.12.9 NMAC - N, 10/15/2003; A, 11/15/2004; A, 12/31/2011; A, 1/1/2023]

11.4.12.11 CAP ON BENEFITS:

A. Notwithstanding the provisions of the Workers' Compensation Act and Occupational Disease Disablement Law, injured employees or an employee's beneficiaries who pursue a claim for benefits from the uninsured employers' fund (UEF) are not guaranteed payment for full workers' compensation benefits from the UEF.

B. The liability of the state, the uninsured employers' fund and the state treasurer, with respect to payment of any compensation benefits, expenses, fees or disbursements properly chargeable against the UEF, is limited to the assets in the UEF, and they are not otherwise liable for any payment. [~~In no case shall the liability of the UEF for payment of indemnity benefits to any worker injured in a job-related accident exceed forty-thousand dollars ($40,000.00) per job related injury or exceed forty-thousand dollars ($40,000.00) for payment of medical benefits per job related injury. If indemnity benefits do not amount to forty-thousand-dollars ($40,000.00), any unused portion can be applied to payment of medical expenses, over and above the forty-thousand-dollars ($40,000.00) limit for medical benefits.~~]

C. For any job-related accident date occurring on or before June 30, 2023, the liability of the UEF for payment of indemnity benefits to an injured worker or their beneficiary shall not exceed $40,000 for each date of accident, nor shall payment of medical expenses $40,000 for each date of accident. If indemnity benefit payments do not reach $40,000, any unused portion can be applied to payment of medical expenses, over and above the $40,000 limit for medical benefits.

D. For any job-related accident date occurring on or after July 1, 2023, payment of indemnity benefits to an injured worker or their beneficiary shall not exceed $60,000 for each date of accident, nor shall payment of medical expenses exceed $60,000 for each date of accident. If indemnity benefit payments do not reach $60,000, any unused portion can be applied to payment of medical expenses, over and above the $60,000 limit for medical benefits.

E. For any job-related accident date occurring on or after July 1, 2025, and subject to the financial solvency of the UEF as determined by the director, payment of indemnity benefits to an injured worker or their beneficiary shall not exceed $75,000 for each date of accident, nor shall payment of medical expenses exceed $75,000 for each date of accident. If indemnity benefit payments do not reach $75,000, any unused portion can be applied to payment of medical expenses, over and above the $75,000 limit for medical benefits.

[11.4.12.11 NMAC - N, 10/15/2003; A, 11/15/2004; N/E, 12/23/2005; A, 1/1/2023]

11.4.12.12 PENALTIES COLLECTED FROM UNINSURED EMPLOYERS: If the WCA director or workers' compensation judge determines that an employer was obligated to pay workers' compensation benefits to or on behalf of a worker and has not done so due to its failure to obtain and keep in force a policy of workers' compensation insurance that is valid pursuant to the Workers' Compensation Act, the WCA director or the workers' compensation judge shall impose a penalty against the employer of not less than fifteen percent and not more than fifty percent of the value of the total award in connection with the claim that shall be paid into the uninsured employers' fund. The determination of the appropriate percentage of penalty imposed shall be treated as a statutorily authorized discretionary act by a state agency, for purposes of judicial review. This penalty is separate from, and in addition, to any penalty or remedy sought against an uninsured employer pursuant to Sections 52-1-61 or 52-1-62 NMSA 1978 for failure to have insurance when required to do so. This penalty is intended to protect the health, safety and welfare of the citizens of the state of New Mexico and shall be considered a governmental penalty for purposes of the dischargeability provisions of the federal bankruptcy code.

A. Any final compensation order addressing the compensability of the workers' claim shall not be subject to collateral attack.

B. The actual benefits provided to or on behalf of a worker or his dependents shall be presumed valid as the basis for the assessment of a penalty.

C. Billing and medical records in the possession of the UEF or the independent adjusting company shall be considered records of the WCA for purposes of authentication.

[~~**D.** Telephonic and videoconferencing shall be permitted to the extent permitted by law to facilitate the participation of the parties.~~]

[~~**E**~~] **D.** The [~~WCA~~] UEF may use any legal process for collecting [~~the~~] any imposed penalty, or collecting reimbursement from the employer for indemnity and medical benefits, costs, and attorneys' fees paid by UEF, including, but not limited to, reduction of the penalty to judgment in district court, seeking and obtaining writs of garnishment and execution, contempt citations or any other legal process in aid of collection and participating as a party in any bankruptcy action, including filing an involuntary petition in federal bankruptcy court to liquidate personal or business assets for the purpose of enforcing the penalty.

[~~**F**~~] **E.** For the purposes of these actions, the [~~WCA~~] UEF shall, at all times act pursuant to the commissions of its personnel as special assistant attorneys general. All proceedings before the WCA director for enforcement of the provisions of this section shall be conducted in accordance with [~~11 NMAC 4.5~~] 11.4.5 NMAC.

[~~**G**~~] **F.** The fund may seek reimbursement of the costs and attorney fees of any legal action instituted in a proceeding to determine or collect a penalty or reimbursement pursuant to this subsection.

[11.4.12.12 NMAC - Rn, 11.4.12.10 NMAC, 12/23/2005; A, 12/31/2011; A, 1/1/2023]

WORKERS COMPENSATION ADMINISTRATION

This is an amendment to 11.4.13 NMAC, Sections 8, 9, and 10, effective 1/1/2023.

11.4.13.8 APPLICATIONS:

A. Any party proposing a controlled insurance plan pursuant to Section 52-1-4.2 NMSA 1978, shall submit an application for approval to the director on a form provided for that purpose not less than 30 days prior to the commencement of bidding procedures for the primary contractor.

(1) A provisional or contingent application for approval shall be allowed, provided that neither final approval nor permission to break ground may be given to any provisional or contingent application.

(2) Approvals of provisional or contingent applications are advisory only and no approval that is not designated as a final approval and that does not bear the signature of the director shall be deemed final.

(3) Every application for approval of a controlled insurance plan shall contain a detailed financial statement demonstrating that the aggregate construction cost, as statutorily defined, has been satisfied, and further showing that the sources of funding for the project conform with the definition of the term, "same project" contained in these rules. The financial statement shall be supported by an affidavit executed by the signatory to the application attesting to the accuracy and completeness of the financial statement.

B. No controlled insurance plan construction project shall break ground until final written approval of the controlled insurance plan, subject to amendment, is provided by the director. The director is authorized to seek injunctive relief to prohibit construction at a site until final approval of an application for a controlled insurance plan is given or the construction project is operated under [~~an~~]a non-controlled insurance plan otherwise complying with the act, in addition to any other relief sought.

C. Failure to provide and maintain current information on the application form on file with the director, and to update any change information within ten calendar days of the change shall constitute a violation of these rules. The applicant shall have a continuing duty to maintain the currency and correctness

of the application on file with the director.

D. Amendments to an application to conform with any modifications to the job, modifications to the safety plan or modifications to the designated single construction site and all other information required by this rule or the application for approval of a controlled insurance plan are required prior to the commencement of work pursuant to the amended provisions.

(1) The insurance policy for a controlled insurance plan must be conformed to any revisions in the application prior to commencement of work pursuant to the revisions.

(2) All contractors and subcontractors shall be notified in writing upon any request for amendment or revision to the application, and shall be separately notified of the approved amendments or revisions prior to the commencement of work pursuant to any approved amendments or revisions.

E. The director or his designee shall be available to applicants for controlled insurance plans to provide counseling in aid of the development of acceptable applications, but in no event shall such assistance be construed as the director's approval of the application or as a promise that the director will approve an application.

F. The director or his designee shall attempt to complete the application review process within 30 days of submission of the final application, and shall inform the applicants in writing of the reasons for, and expected duration of, any delay beyond the 30 day period.

G. The applicants shall specify the names of at least two individuals authorized to accept notices and service of process applicable to the controlled insurance plan. For each named individual, both street and mailing addresses shall be specified, and the applicant shall notify the WCA of any changes in the authorized representatives for receipt of notices and process or the applicable addresses for such representatives within [~~three~~] 10 business days of any such change.

H. The applicant shall specify the name of at least one person, who may also be designated to perform other functions under this part, who is knowledgeable concerning the handling of workers' compensation claims under the act. The director shall approve the designated claims management professional after submission of credentials and resume, prior to the commencement of the work. The designated claims management professional shall be available within 24 hours of any accident at the single construction site and shall consult with the injured worker's employer within 72 hours of any accident at the single construction site, concerning the handling of the claim and return to work issues.

[11.4.13.8 NMAC - N, 11/15/2004; A, 1/1/2023]

11.4.13.9 CONTROLLED INSURANCE PLAN CONSIDERATION UNDER THE EXTRA-HAZARDOUS EMPLOYER PROVISIONS OF THE WORKERS' COMPENSATION ACT:

The controlled insurance plan shall be considered a single employer for purposes of WCA regulations concerning extra-hazardous employers, promulgated pursuant to [~~Subsection (B) of Section 52-5-1.3~~] Subsection (E) of Section 52-1-6.2 NMSA 1978. The North American industrial classification system (NAICS) code applicable to the general contractor shall be the industry code utilized for comparison of the controlled insurance plan loss record to its industry standard. The controlled insurance plan project shall be examined every 90 days, while construction is ongoing, for purposes of determining extra- hazardous employer status.

[11.4.13.9 NMAC - N, 11/15/2004; A, 1/1/2023]

11.4.13.10 SAFETY PLANS:

A. Criteria for approval. The following requirements must be met for initial approval of a safety plan and for final approval of an application for a controlled insurance plan. Failure to maintain continuous compliance with each of these requirements shall be considered a violation of these rules and the director shall be authorized to seek injunctive action to prohibit construction work until such failure is corrected.

(1) New Mexico OSHA compliance;

(2) Appointment of a site safety manager acceptable to the director;

(a) The site safety manager shall have a minimum of three-year's experience in programs covered by 29 CFR part 1910 or 29 CFR part 1926, as applicable.

(b) An applicant shall submit a resume and credentials of the proposed site safety manager not less than 14 days before commencement of work on the project. The director, or his designee, shall review the resume credentials within 14 days. Work on the project shall not commence until the director or his designee has approved a site safety manager.

(c) An applicant shall submit a resume and credentials for any proposed substitute or standby site safety manager prior to any construction activities at the single construction site overseen by the substitute or standby site safety manager.

(d) In no event shall the applicant allow work at the single construction site to proceed for more than eight continuous hours without the approved site safety manager, or approved substitute or backup site safety manager being physically present at the single construction site.

(e) All approved safety plans must provide that the approved site safety manager, or approved standby or substitute site safety manager shall have plenary authority to close down the construction project in whole or

in part, in the event that hazards to health or safety of workers present an imminent danger to worker health or safety. The approved site safety manager, backup site safety manager or substitute site safety manager has a duty to close down the construction project, in whole or in part, upon discovery of an imminent danger to worker health or safety that cannot be immediately rectified.

(3) A plan for coordination of site safety programs among all contractors and subcontractors by the site safety manager, including access for contractor and subcontractor safety personnel.

(a) The plan shall provide for review of the controlled insurance plan safety plan and drug and alcohol testing provisions by safety personnel employed by, or contracted to, individual contractors and subcontractors.

(b) The plan shall provide that any safety provisions, and drug and alcohol testing programs required by the contractor or subcontractor that are more stringent in the safety provisions or drug and alcohol testing programs required by the approved safety plan shall be enforceable against the employees and working conditions of the contractor or subcontractor and shall not be superseded by the approved controlled insurance plan safety plan or the approved controlled insurance plan drug and alcohol screening program.

(4) Third party safety consultant

(a) The applicant shall engage the services of an independently contracted safety consultant ("third party safety consultant") to provide independent inspections and oversight on safety issues to assist the site safety manager and the WCA.

(i) The third party safety consultant shall conduct work environment evaluation inspections of the single construction site at least twice per month during construction activities.

(ii) The third party safety consultant shall notify the site safety manager immediately of any hazardous condition disclosed by the third party safety consultant's inspection

(iii) The third party safety consultant shall not be terminated in response to making a good-faith finding that a safety hazard exists or in response to reporting such safety violations as provided by these rules.

(b) The third party safety consultant shall have credentials at least equal to those required of the site safety manager.

(c) The third party safety consultant shall not be the backup site safety manager.

(d) The credentials of the third party safety consultant shall be presented to, and approved in writing by, the WCA prior to the commencement of construction

(e) In the event that the third party safety consultant is replaced during construction activities, the credentials of the replacement third party safety consultant shall be presented to the WCA within no more than [~~five~~] 10 working days of the earlier of the termination of the contract or the cessation of work by the prior third party safety consultant.

(f) The third party safety consultant shall prepare written reports at least every 30 days from the date of commencement of construction detailing any safety issues or hazards discovered during the inspections that occurred during the prior month. Said reports shall be provided to the WCA, all contractors and all sub-contractors.

(g) The third party safety consultant shall also generate a written report in the event that he or she discovers any condition or hazards that constitute an imminent danger to worker health or safety that the independent safety consultant believes would justify closure of the construction site in whole or in part by the site safety manager. Said report shall be provided to the WCA, all contractors and all subcontractors within 2 days of the discovery of the condition or hazard.

(5) Drug and alcohol screening, complying with provisions of Section 52-1-12.1 NMSA 1978. Compliance with the drug and alcohol screening plan shall be the responsibility of the applicant provided that the applicant shall implement any more stringent plan incorporated pursuant to Subparagraph (a) of Paragraph (3) of Subsection A of 11.4.13.10 NMAC.

(6) Continuous coverage of the construction site shall be provided by an on-site registered nurse, who shall have demonstrated experience in the treatment of workers' compensation claimants, during all working hours.

(a) Credentials and resume for the registered nurse must be presented to the WCA and approved prior to the beginning of construction.

(b) Credentials for any registered nurse serving in a backup capacity or as a substitute for the original approved registered nurse must be presented to the WCA and approved prior to the first instance of coverage by that nurse.

(c) Should the retention of a registered nurse constitute a hardship on the applicant because of location or any other circumstance, the applicant may petition the director for a waiver of this requirement pursuant to 11.4.13.11 NMAC and the substitution of a certified, full-time, emergency medical technician (EMT). The applicant must demonstrate compliance.

(7) Emergency medical services plan

(a) The plan must include a provision requiring prominent display at the work site giving notice to workers of emergency facilities to be used in the event of an accident, including a map directing workers to the appropriate emergency facilities.

(b) The plan must include a provision requiring prominent display at the work site of notices concerning any contracted physicians or medical facilities.

(c) The plan must contain a provision for providing notice of initial choice of health care providers to workers, in compliance with WCA regulations.

(d) The plan must contain evidence of planning and contractual preparation for emergency medical evacuation by air, when medically appropriate.

(8) Evidence of a plan for facilitating return to work of injured employees.

(a) The plan must provide for appropriate communication to workers to ensure to the extent possible they are fully apprised concerning return to work policies.

(b) The plan must provide for the direct involvement of the employer of the injured worker in return to work planning and implementation commencing as soon as possible after the injury to the worker.

(c) The plan must provide for continued communication concerning return to work between the insurer, the worker and employer for all injuries persisting beyond the completion of the project.

(9) The site safety manager must certify to the owner of the property upon which the controlled insurance plan project is being built, all contractors and subcontractors and to the independent safety consultant, and to the WCA, that each worker on the single construction site has been specifically safety trained for each job function that they perform, within 10 days of the commencement, or change, of the workers job duties on the single construction site. The certification shall be on a form approved by the director.

(10) The plan must provide for communications provided to the applicant regarding substance abuse testing, medical treatment and medical conditions, or injury reports to be promptly and specifically communicated to the workers employer within four calendar days of the communication to the applicant. The applicant is solely responsible for this requirement. The applicant shall specify, to the WCA and to each contractor and subcontractor, before the commencement of work at the single construction site, the names of at least two persons working full time at the single construction site who are authorized to assist the applicant in fulfilling this responsibility.

B. Failure to obtain approval for a safety plan or to maintain compliance with an approved safety plan is a serious violation of these rules and the director is authorized to seek injunctive relief to prevent commencement or continuation of construction until such situation is remedied in addition to any other relief sought.

[11.4.13.10 NMAC - N, 11/15/2004; A, 12/29/2006; A, 1/1/2023]

End of Adopted Rules

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Other Material Related to Administrative Law

GOVERNOR, OFFICE OF THE

EXECUTIVE ORDER 2022-165

RENEWING THE STATE OF PUBLIC HEALTH EMERGENCY INITIALLY DECLARED IN EXECUTIVE ORDER 2020-004, OTHER POWERS INVOKED IN THAT ORDER, AND ALL OTHER ORDERS AND DIRECTIVES CONTAINED IN EXECUTIVE ORDERS TIED TO THE ONGOING PUBLIC HEALTH EMERGENCY

On December 31, 2019, several cases of pneumonia with an unknown cause were detected in Wuhan City, Hubei Province, China, and reported to the World Health Organization ("WHO"). The underlying virus giving rise to those reported instances of respiratory illness was later identified as a novel coronavirus disease which has been referred to as "COVID-19."

By the time the first COVID-19 cases had been confirmed in New Mexico, on March 11, 2020, COVID-19 had already spread globally and throughout the United States. At that time, more than 100,000 people had been infected globally and there were more than 1,000 cases in the United States, spread out over 39 states. The President of the United States declared a national state of emergency for COVID-19 on March 13, 2020. As of December 8, 2022, the Centers for Disease Control and Prevention ("CDC") reported over 99.2 million people have been infected in the United States, with over 1,080,000 related deaths, and the New Mexico Department of Health has reported 651,520 positive COVID-19 cases and 8,736 related deaths in New Mexico.

Public health organizations have implemented emergency measures intended to slow the spread of COVID-19. For example, on January 20, 2020, the CDC activated its Emergency Operations Center in response to the COVID-19 outbreak. The WHO declared a Public Health Emergency of International Concern shortly thereafter. All of our sister states subsequently declared a state of emergency and implemented significant measures and deployed substantial resources to fight the spread of COVID-19; many have kept such states of emergency in place.

New Mexico has taken aggressive measures to reduce the spread of COVID-19 and to mitigate its impacts. I have been in frequent contact with federal and state agencies and officials who are coordinating their efforts and resources to fight COVID-19. Various state agencies have been at the forefront of our State's response to COVID-19, particularly the New Mexico Department of Health. The hard work of a variety of state employees has made a difference in our fight against COVID-19. Due to the continued spread of COVID-19, it is necessary for all branches of State government to continue taking actions to minimize transmission of COVID-19 and to reduce its attendant physical and economic harms.

Therefore, for the reasons above, I, Michelle Lujan Grisham, Governor of the State of New Mexico, by virtue of the authority vested in me by the Constitution and laws of the State of New Mexico, hereby **ORDER** and **DIRECT**:

1. In consultation with the New Mexico Department of Health, I have determined that the statewide public health emergency proclaimed in Executive Order 2020-004, and renewed in Executive Orders 2020-022, 2020-026, 2020-030, 2020-036, 2020-053, 2020-55, 2020-059, 2020-064, 2020-073, 2020-080, 2020-085, 2021-001, 2021-004, 2021-010, 2021-011, 2021-012, 2021-023, 2021-030, 2021-044, 2021-049, 2021-054, 2021-058, 2021-061, 2021-067, 2022-004, 2022-007, 2022-012, 2022-016, 2022-024, 2022-067, 2022-109, 2022-115, 2022-120, 2022-131, 2022-147, and 2022-149 shall be renewed and extended through January 6, 2023.

2. All other powers, directives, and orders invoked in Executive Order 2020-004 remain in effect.

3. Unless previously rescinded, all other Executive Orders with a duration that was tied to the COVID-19 public health emergency or that was not explicitly stated shall continue with the same effect, including any orders appropriating emergency funding as well as Executive Orders 2020-020.

4. This Order supersedes any previous orders, proclamations, or directives in conflict. This Order shall take effect immediately, and shall remain in effect until January 6, 2023, unless renewed, modified, or rescinded.

ATTEST:
DONE AT THE EXECUTIVE OFFICE THIS 9TH DAY OF DECEMBER 2022

WITNESS MY HAND AND THE GREAT SEAL OF THE STATE OF NEW MEXICO

/ S /
MAGGIE TOULOUSE OLIVER
SECRETARY OF STATE

/ S /
MICHELLE LUJAN GRISHAM
GOVERNOR

HEALTH, DEPARTMENT OF

PUBLIC HEALTH ORDER NEW MEXICO DEPARTMENT OF HEALTH ACTING SECRETARY DAVID R. SCRASE, M.D.

December 19, 2022

Amended Public Health Emergency Order Clarifying All Orders, Directives, Guidance and Advisories Remaining in Effect and Imposing Certain Public Health Measures

PREFACE

The purpose of this amended Public Health Emergency Order is to provide current guidance regarding all mandates and clarify all public health orders remaining in effect in relation to the Novel Coronavirus Disease 2019 ("COVJD-19"). All New Mexicans should continue to adhere to social distancing protocols when required to protect our State as a whole.

WHEREAS, on March 11, 2020, because of the spread of the novel Coronavirus Disease 2019 ("COVID-19"), Michel le Lujan Grisham, the Governor of the State of New Mexico, declared that a Public Health Emergency exists in New Mexico under the Public Health Emergency Response Act, and invoked her authority under the All Hazards Emergency Management Act;

WHEREAS, Governor Michelle Lujan Grisham has renewed the declaration of a Public Health Emergency through January 6, 2023;

WHEREAS, confirmed cases in the United States have risen to more than 99.7 million and confirmed COVID-19 infections in New Mexico have risen to over 655,000;

WHEREAS, COVID-19 is a deadly virus and has taken the lives of over I,083,000 Americans and over 8,700 New Mexicans;

WHEREAS, the spread of COVID-19 in the State of New Mexico poses an ongoing threat to the health, safety, wellbeing and property of the residents in the State due to, among other things, illness from COVID-19, illness-related absenteeism from employment, potential displacement of persons, and closures of schools or other places of public gathering;

WHEREAS, nonetheless, we now have effective tools and practices to minimize the spread of COVID- 19, such as COVID vaccination, earlier home-based COVID testing with adequate quarantine for those who are exposed and isolation of those who test positive, early COVID therapeutic treatment for those who test positive, the consistent and proper use of more effective face coverings, and more robust and community-specific data reporting to guide individuals and communities based on current case counts and hospitalization rates; and the effectiveness of these new tools and practices warrant the lifting of certain restrictions placed upon the State;

WHEREAS, for example, it is now no longer necessary to require State correctional facilities workers to be vaccinated against COVID-19 in light of high vaccination rates and the additional tools and practices mentioned above, and lifting this requirement may help the State fill staff vacancies, which will in turn help ensure the health and safety of those working or incarcerated in those facilities; however, those workers are still strongly urged to be fully vaccinated against COVID-19 ant to receive any recommended booster doses;

WHEREAS, the protection of our most vulnerable New Mexicans, including those who are immune compromised or have other pre-existing conditions that place them at high risk for serious COVID-illness, remains of paramount importance; and

WHEREAS, the New Mexico Department of Health ("NMDOH") possesses legal authority pursuant to the Public Health Act, NMSA 1978, Sections 24-1-1 to -40, the Public Health Emergency Response Act, NMSA 1978, Sections 12-10A-1 to -19, the Department of Health Act, NMSA 1978, Sections 9-7-1 to -18, and inherent constitutional police powers of the New Mexico state government, to preserve and promote public health and safety.

NOW, THEREFORE, I, David R. Scrase, M.D., Acting Secretary of the New Mexico Department of Health, in accordance with the authority vested in me by the Constitution and the Laws of the State of New Mexico, and as directed by the Governor pursuant to the full scope of her emergency powers under the All Hazard Emergency Management Act, do hereby **DECLARE** the current outbreak of COVID-19 a condition of public health importance, as defined in NMSA 1978, Section 24-l-2(A) as an infection, a disease, a syndrome, a symptom, an injury or other threat that is identifiable on an individual or community level and can reasonably be expected to lead to adverse health effects in the community, and that poses an imminent threat of substantial harm to the population of New Mexico.

ORDER

I HEREBY DIRECT AS FOLLOWS:

(l) All Public Health Emergency Orders adopted in relation to the COVID-19 public health emergency are hereby rescinded, and only those directives stated herein shall remain in effect until otherwise amended or rescinded.

(2) All current guidance documents and advisories issued by the Department of Health

in response to the COVID-19 public health emergency remain in effect.

I FURTHER DIRECT:

(1) All facilities licensed or certified by the Centers for Medicare and Medicaid Services ("CMS"), including all hospital types, long-term care facilities, hospice facilities, and rehabilitation facilities are instructed to adhere to all COVID-related requirements prescribed by CMS, including, but not limited to, masking and patient/staff vaccination. Facilities reporting staff vaccination status in the federal CMS reporting system are not required to concurrently report such data to the state reporting system. NMDOH no longer requires weekly testing for healthcare workers whose vaccine status is not up to date.

(2) For the duration of the public health emergency all assisted living facilities and adult day care settings are required to adhere to all COVID-related requirements to which hospitals and nursing homes are held by CMS, including, but not limited to, masking and vaccination. These facilities will continue to report staff vaccination status to the State as long as CMS requires such reporting, at the same frequency as required by CMS for the facility types listed in paragraph I above.

(3) All facilities subject to paragraphs 1 and 2 above are advised to evaluate Centers for Disease Control and Prevention ("CDC") community transmission levels in their locality and adopt more stringent precautions, if needed. CDC community transmission levels can be accessed via the following link: https://covid.cdc.gov/covid-data-tracker/#county view?list_ select_state=New+Mexico&data-type=Risk&null=Risk.

(4) All New Mexicans should remain aware of the importance of protecting our most vulnerable population groups, including those who are older, immune compromised, or have other pre-existing conditions that place them at high risk for serious COVID illness. Additional information from the CDC about risks for illness can be accessed via the following link: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

(5) All New Mexicans should be aware that there are now tools that can be used to direct both isolation for those who have acquired COVID and quarantine for those who have been exposed to COVID. In these two situations, all New Mexicans are strongly encouraged to use the CDC Quarantine and Isolation Calculator that can be accessed via the following link: https://www.cdc.gov/coronavirus/20 l9-ncov/your-health/quarantine-isolation.html.

(6) All businesses, establishments, and non-profit entities are recommended to adhere to the latest CDC guidance for Workplace and Businesses available via the following link: https://www.cdc.gov/niosh/emres/2019_ncov_default.html. Businesses, establishments, and non-profit entities are further recommended to adhere to CDC guidance for Cleaning and Disinfecting Your Facility, which may be accessed via the following link: https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html?CDC_AA_reVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F20 l9- ncov%2Fcommunity%2Forganizations%2Fcleaning-disinfection.html.

(7) Nothing in this Order shall be construed as prohibiting any business, house of worship, non-profit entity, or other entity from imposing more stringent requirements.

(8) Public, private, and charter educational institutions shall adhere to the "COVID-19 Response Toolkit for New Mexico's Public Schools," available at https://webnew.ped.state.nm.us/reentry-district-and-school-guidance/ and may operate up to maximum capacity. Public and private educational institutions shall follow the reporting, testing, and closure requirements set forth by the Public Education Department in the COVID-19 Response Toolkit for New Mexico's Public Schools.

(9) All Long-Term Care Facilities, including nursing homes, assisted living facilities, and hospice facilities must stay apprised and comply with the applicable directives and guidelines issued by the Department of Health in consultation with the Aging and Long-Term Services Department, which are available on the NMDOH website.

I FURTHER DIRECT as follows:

(1) This Order shall be broadly disseminated in English, Spanish, and other appropriate languages to the citizens of the State of New Mexico.

(2) This Order shall take effect immediately and remain in effect until amended or rescinded by the Secretary.

ATTEST:
DONE AT THE EXECUTIVE OFFICE

THIS 19TH DAY OF DECEMBER 2022
WITNESS MY HAND AND THE GREAT SEAL OF THE STATE OF NEW MEXICO

/ S /
MAGGIE TOULOUSE OLIVER
SECRETARY OF STATE

/ S /
DAVID R. SCRASE, M.D.
ACTING SECRETARY OF THE NEW MEXICO DEPARTMENT OF HEALTH

End of Other Material Related to Administrative Law

2023 New Mexico Register

Submittal Deadlines and Publication Dates

Volume XXXIV, Issues 1-24

Issue	Submittal Deadline	Publication Date
Issue 1	January 5	January 18
Issue 2	January 19	January 31
Issue 3	February 2	February 14
Issue 4	February 16	February 28
Issue 5	March 2	March 14
Issue 6	March 16	March 28
Issue 7	March 30	April 11
Issue 8	April 13	April 25
Issue 9	May 4	May 16
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Issue 20	October 12	October 24
Issue 21	October 26	November 7
Issue 22	November 9	November 21
Issue 23	November 22	December 5
Issue 24	December 7	December 19

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