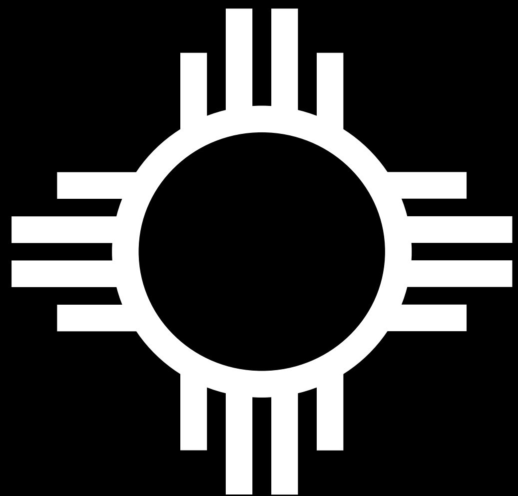
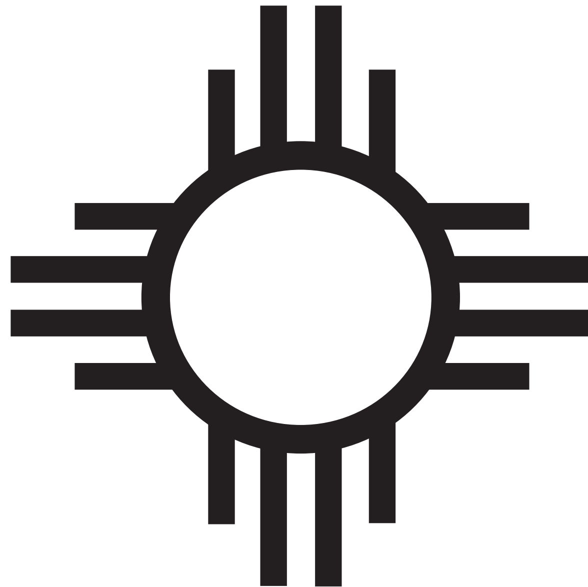
NEW MEXICO REGISTER



Volume XXVI
Issue Number 18
September 29, 2015

New Mexico Register

Volume XXVI, Issue 18
September 29, 2015



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

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2015

COPYRIGHT © 2015
BY
THE STATE OF NEW MEXICO

ALL RIGHTS RESERVED

New Mexico Register

Volume XXVI, Issue 18
September 29, 2015

Table of Contents

Notices of Rulemaking and Proposed Rules

Environmental Improvement Board
Notice of Rulemaking Hearing....782
Notificacion de Reunion Publica y Audiencia de Reglamentacion....782
Notice of Public Hearing to Consider Proposed Amendments to 7.6.2 NMAC....783

Human Services Department
Income Support Division
Notice of Public Hearing....784

Public Education Department
Notice of Proposed Rulemaking....784

Public Employees Retirement Association
Notice of P.E.R.A. Rulemaking....785

Public Regulation Commission
Notice of Proposed Rulemaking Case No. 15-00264-UT....785

Secretary of State
Notice of Proposed Rulemaking....786

Workers' Compensation Administration
Notice of Public Hearing....786

Workforce Solutions, Department of
Notice of Public Hearing....786

Adopted Rules

A = Amended, E = Emergency, N = New, R = Repealed, Rn = Renumbered

Children, Youth and Families Department

8.10.3 NMAC	R	Protective Services Investigation	788
8.10.8 NMAC	R	Permanency Planning	788
8.10.3 NMAC	N	Protective Services Investigation	788
8.10.8 NMAC	N	Permanency Planning	794
8.10.2 NMAC	A	Protective Services Intake	800
8.10.9 NMAC	A	Youth Services	802
8.15.2 NMAC	A	Requirements for Child Care Assistance Programs For Clients and Child Care Providers	806
8.26.2 NMAC	A	Placement Services	809

Game and Fish, Department of

19.30.9 NMAC	R	Game and Fish Licenses/Permits	815
19.30.9 NMAC	N	Game and Fish Licenses/Permits	815

Human Services Department
Income Support Division
8.102.500 NMAC A Eligibility Policy - General Information....................................818
8.106.500 NMAC A Eligibility Policy - General Information....................................819
8.139.500 NMAC A Financial Eligibility - Need Determination................................820
8.150.100 NMAC A General Provisions for the Low Income Home Energy Assistance Program..822
8.150.110 NMAC A Applications...824
8.150.410 NMAC A General Recipient Requirements..825
8.150.500 NMAC A Eligibility...826
8.150. 520 NMAC A Earned Income..827
8.150.600 NMAC A Description of Program/Benefits..827
8.150.620 NMAC A Benefit Determination General..828
Medical Assistance Division
8.206.400 NMAC R Recipient Requirements..829
8.206.400 NMAC N Recipient Requirements..829

Mining Safety Board
19.6.2 NMAC A Emergency Notifications...831

Public Schools Insurance Authority
6.50.1 NMAC A Insurance - General Provisions...835
6.50.10 NMAC A Employee Benefit Coverage Enrollment Policy..........................835

Regulation and Licensing Department
Physical Therapy Board
16.20.10 NMAC A Direct Care Requirements..835

Workers' Compensation Administration
11.4.8 NMAC R Individual Self-Insurance..836
11.4.8 NMAC N Individual Self-Insurance..836
11.4.3 NMAC A Payment of Claims and Conduct of Parties................................841
11.4.4 NMAC A Claims Resolution...841
11.4.7 NMAC A Payments For Health Care Services..850
11.4.9 NMAC A Group Self-Insurance...857

Other Material Related To Administrative Law

Workers' Compensation Administration
Response To Public Comment On Proposed Rulemaking..862

The New Mexico Register

Published by
The Commission of Public Records
Administrative Law Division
1205 Camino Carlos Rey
Santa Fe, NM 87507

The *New Mexico Register* is published twice each month by the Commission of Public Records, Administrative Law Division.
The cost of an annual subscription is $270.00. Individual copies of any Register issue may be purchased for $12.00.
Subscription inquiries should be directed to: The Commission of Public Records,
Administrative Law Division, 1205 Camino Carlos Rey, Santa Fe, NM 87507.
Telephone: (505) 476-7942; Fax: (505) 476-7910;
e-mail: staterules@state.nm.us.
The ***New Mexico Register*** is available free at http://www.nmcpr.state.nm.us/nmregister

Notices of Rulemaking and Proposed Rules

ENVIRONMENTAL IMPROVEMENT BOARD

Notice Of Rulemaking Hearing

The New Mexico Environmental Improvement Board ("Board") will hold a public hearing on December 18, 2015 at 9:00 a.m. in room 307 of the New Mexico State Capitol Building, 490 Old Santa Fe Trail, Santa Fe, New Mexico. The purpose of the hearing is to consider the matter of EIB 15-03 (R), a proposed repeal of 20.2.36 NMAC, *Petroleum Refinery - Sulfur*.

The proponent of this regulatory amendment is the New Mexico Environment Department ("NMED").

The purpose of the public hearing is to consider and take possible action on a petition from the NMED to repeal 20.2.36 NMAC. The purpose of the proposed repeal of 20.2.36 NMAC is to remove outdated, redundant requirements.
The federal New Source Performance Standards (NSPS) regulations, 40 CFR Part 60, Subparts J and Ja and other permit requirements require sulfur emission limits that are more directly related to air emissions of sulfur than 20.2.36 NMAC, and require continuous monitoring, which provides for more effective enforcement of the emission limits. Since these federal regulations are in place for sulfur limits for existing and future refineries, a repeal of 20.2.36 NMAC would not negatively affect air quality.

The NMED will host informational open houses on the proposed repeal of 20.2.36 NMAC at the NMED Roswell Office training room, 1914 W. Second, Roswell, NM 88201 from 2:30 p.m. to 4:30 p.m. on Thursday, October 29, 2015 and at the NMED Albuquerque District Office, 121 Tijeras Ave. NE, STE 1000, Albuquerque, NM 87102 in the Alameda conference room from 3:30 p.m. to 5:30 p.m. on Tuesday November 3, 2015. For questions regarding the open house, please contact Mark Jones at 505-566-9746 or mark.jones@state.nm.us.

Full text of NMED's proposed repealed regulation is available on NMED's web site at www.env.nm.gov/aqb or by contacting Mark Jones at 505-566-9746 or mark.jones@state.nm.us. The proposed repealed regulation may also be examined during office hours at the Air Quality Bureau office, 525 Camino de los Marquez, Suite 1, Santa Fe, New Mexico.

The hearing will be conducted in accordance with 20.1.1 NMAC (*Rulemaking Procedures – Environmental Improvement Board*), the *Environmental Improvement Act*, NMSA 1978, Section 74-1-9, the *Air Quality Control Act*, NMSA 1978, Section 74-2-6, and other applicable procedures.

All interested persons will be given reasonable opportunity at the hearing to submit relevant evidence, data, views and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Persons wishing to present technical testimony must file with the Board a written notice of intent to do so. The notice of intent shall:

(1) identify the person for whom the witness(es) will testify;
(2) identify each technical witness that the person intends to present and state the qualifications of the witness, including a description of their education and work background;
(3) include a copy of the direct testimony of each technical witness in narrative form;
(4) include the text of any recommended modifications to the proposed regulatory change; and
(5) list and attach all exhibits anticipated to be offered by that person at the hearing, including any proposed statement of reasons for adoption of rules.

Notices of intent for the hearing must be received in the Office of the Board not later than 5:00 pm on November 25, 2015, and should reference the docket number, EIB 15-03 (R), and the date of the hearing. Notices of Intent to present technical testimony should be submitted to:

Pam Castañeda, Board Administrator
Environmental Improvement Board
1190 S. St. Francis Drive, Room S-2102
Santa Fe, NM 87502
Phone: (505) 827-2425, Fax (505) 827-0310

Any member of the general public may testify at the hearing. No prior notification is required to present non-technical testimony at the hearing. Any such member may also offer exhibits in connection with his testimony, so long as the exhibit is not unduly repetitious of the testimony.

A member of the general public who wishes to submit a written statement for the record, in lieu of providing oral testimony at the hearing, shall file the written statement prior to the hearing, or submit it at the hearing.

Persons having a disability and needing help in being a part of this hearing process should contact J.C. Borrego of the NMED Human Resources Bureau by December 1, 2015 at P.O. Box 5469, 1190 St. Francis Drive, Santa Fe, New Mexico, 87502, telephone 505-827-0424 or email juancarlos.borrego@state.nm.us. TDY users please access his number via the New Mexico Relay Network at 1-800-659-8331.

The Board may make a decision on the proposed revised regulation at the conclusion of the hearing, or the Board may convene a meeting after the hearing to consider action on the proposal.

ENVIRONMENTAL IMPROVEMENT BOARD

Notificación De Reunión Pública Y Audiencia De Reglamentación

La Junta de Mejora Ambiental de Nuevo México ("Junta") celebrará una audiencia pública el 18 de Diciembre, 2015 a las 9:00 a.m. en el edificio del Capitolio del Nuevo México, Sala 307, Santa Fe, Nuevo México. El propósito de la audiencia es considerar el asunto de EIB 15-03 (R), una propuesta de derogación de 20.2.36 NMAC , Refinería – Azufre.

El proponente de esta revocación y reemplazo reguladora es el Departamento del Medio Ambiente de Nuevo México ("NMED").

El propósito de la audiencia pública es considerar y tomar una posible acción en una petición del NMED derogar 02/20/36 NMAC. El propósito de la propuesta de derogación de 20.2.36 NMAC es eliminar requisitos anticuados, redundantes.
Las Normas de Desempeño de Nuevas Fuentes (NSPS) las regulaciones federales, 40 CFR Parte 60, otros requisitos del permiso subpartes J y Ja

y requieren límites de emisión de azufre que están más directamente relacionados con las emisiones atmosféricas de azufre que el 20.2.36 NMAC, y requieren un seguimiento continuo, que prevé una aplicación más efectiva de los límites de emisión. Dado que estas regulaciones federales están en su lugar para los límites de azufre de las refinerías existentes y futuras, la derogación de 20.2.36 NMAC no afectaría negativamente a la calidad del aire.

El NMED acogerá jornadas de puertas abiertas de información sobre la propuesta de derogación de 20.2.36 NMAC a la sala de entrenamiento NMED Oficina Roswell, 1914 W. En segundo lugar, Roswell, NM 88 201 14:30-16:30 en Jueves, 29 de octubre 2015 y en la Oficina del Distrito NMED Albuquerque, 121 Tijeras Ave. NE, STE 1000, Albuquerque, NM 87102, en la sala de conferencias Alameda 15:30-17:30 el martes 3 de noviembre de 2015. Si tienes preguntas sobre la jornada de puertas abiertas, por favor póngase en contacto con Mark Jones al 505-566-9746 mark.jones@state.nm.us.

Texto completo de la regulación derogada propuesto por NMED está disponible en el sitio Web de NMED en www.env.nm.gov/aqb o poniéndose en contacto con Mark Jones al 505-566-9746 or mark.jones@state.nm.us. La regulación revisada propuesta podrá ser examinada en horario de oficina en la Oficina de la Agencia de Calidad del Aire del NMED, en 525 Camino de los Marquez, Suite 1, Santa Fe, Nuevo México.

La audiencia se realizará de conformidad con 20.1.1 NMAC (Procedimientos de Reglamentación – Consejo para la Mejora del Medio Ambiente), la Ley de Mejora del Medio Ambiente, Sección 74-1-9 NMSA 1978, la Ley de Control de Calidad del Aire, Sección, 74-2-6 NMSA 1978, y otros procedimientos aplicables.

Todas las personas interesadas tendrán oportunidad razonable en la audiencia de presentar pruebas, datos, opiniones y argumentos importantes, ya sea en forma verbal o por escrito, así como de presentar anexos e interrogar testigos. Las personas que deseen entregar testimonios técnicos deben presentar ante el Consejo una notificación por escrito de su intención. La notificación de intención deberá:

(1) identificar a la persona para quien testificará(n) el(los) testigo(s);
(2) identificar a cada uno de los testigos técnicos que las personas desean presentar y declarar las cualificaciones de los mismos, incluyendo una descripción de sus antecedentes de educación y trabajo;
(3) resumir o incluir una copia del testimonio directo de cada testigo técnico y declarar la duración prevista del testimonio de ese testigo;
(4) enumerar y describir, o adjuntar, cada uno de los anexos que dicha persona prevé ofrecer en la audiencia; y
(5) adjuntar el texto de cualquier modificación recomendada a las regulaciones propuestas nuevas y revisadas.

Las notificaciones de intención para la audiencia deben ser recibidas en la Oficina del Consejo a más tardar a las 5:00 p.m., el 25 de Noviembre de 2015, y hacer referencia al número de expediente, EIB 15-03(R), y la fecha de la audiencia. Las notificaciones de intención para presentar testimonios técnicos se deben entregar a:

Pam Castañeda, Administradora de la Junta
Oficina de la Junta de Mejoramiento Ambiental
1190 S. St. Francis Drive, Room S-2102
Santa Fe, NM 87502
Teléfono: (505) 827-2425, Fax (505) 827-0310

Cualquier miembro del público en general puede testificar en la audiencia. No se requiere notificación previa para presentar testimonios no técnicos en la audiencia. Los miembros del público también pueden ofrecer anexos en relación con su testimonio, en tanto no sean repeticiones excesivas de su testimonio.

Los miembros del público en general que deseen presentar una declaración por escrito para el registro, en vez de ofrecer testimonio verbal en la audiencia, presentarán la declaración por escrito antes de la audiencia, o la presentarán en la misma.

Las personas con discapacidad y que necesiten ayuda para ser parte de este proceso de la audiencia deberán contactar a Juan Carlos Borrego de la oficina de recurso humanos NMED por 01 de julio, 2014, P.O. Box 26110, 1190 St. Francis Drive, Santa Fe, Nuevo México, 87502, teléfono 505-827-0424 o correo electrónico juancarlos.borrego@state.nm.us. Los usuarios de TDY deben acceder a su número a través de la Red de Difusión de Nuevo México, al 1-800-659-8331.

La Junta puede tomar la decisión sobre las regulaciones propuestas revisadas a la conclusión de la audiencia, o bien acordar una reunión para una fecha posterior a fin de considerar las acciones sobre la propuesta.

ENVIRONMENTAL IMPROVEMENT BOARD

Notice Of Public Hearing To Consider Proposed Amendments To 7.6.2 NMAC - Food Service And Food Processing

The New Mexico Environmental Improvement Board (Board) will hold a public hearing beginning at 9:00 a.m. on Friday, December 18, 2015, and continuing thereafter as necessary at the New Mexico State Capitol Building, Room 307, 490 Old Santa Fe Trail, Santa Fe, New Mexico. The hearing location may change prior to the hearing date, and those interested in attending should check the EIB website: http://www.env.nm.gov/eib/ prior to the hearing. The purpose of the hearing is to consider proposed amendments to the Food Service and Food Processing Rules, 7.6.2 NMAC (Rules). The New Mexico Environment Department (NMED) is the proponent of the amendments to the Rules.

The amendments proposed by NMED to 7.6.2 NMAC would adopt the federal Food and Drug Administration 2013 Model Food Code, with a number of additions, modifications, and omissions. The proposed amendments also include changes to the regulations applicable to mobile and temporary food establishments and food processors, as well as requirements for food manager and food employee certification to handle and serve food.

In addition, the proposed amendments include several other minor changes and clarifications to current definitions, regulations, and procedures. Please note that formatting and minor technical changes in the regulations other than those proposed by NMED may be proposed at the hearing. In addition, the Board may make other changes as necessary to accomplish the purpose of providing public health and safety in response to public comments and evidence presented at the hearing.

The proposed changes may be reviewed during regular business hours at the office of the Environmental Improvement Board located in the Harold Runnels Building,

1190 St. Francis Drive, Room N-2150
Santa Fe, NM, 87505. In addition, a copy of the NMED proposed amendments is posted on the NMED website at http://www.env.nm.gov/fod/Food_Program/Regulation_Update.htm

The hearing will be conducted in accordance with 20.1.1 NMAC (Rulemaking Procedures - Environmental Improvement Board), the Environmental Improvement Act, Section 74-1-9 NMSA 1978, and other applicable procedures.

All interested persons will be given reasonable opportunity at the hearing to submit relevant evidence, data, views and arguments, orally or in writing, to introduce exhibits, and to examine witnesses. Any person who wishes to submit a non-technical written statement for the record in lieu of oral testimony must file such statement prior to the close of the hearing.

Pursuant to 20.1.1.302 NMAC, persons wishing to present technical testimony must file with the Board a written notice of intent to do so on or before 5:00 p.m. on November 30, 2015. The notice of intent shall:

- identify the person or entity for whom the witness(es) will testify;

- identify each technical witness that the person intends to present and state the qualifications of the witness, including a description of his or her education and work background;

- include a copy of the direct testimony of each technical witness in narrative form;

- include the text of any recommended modifications to the proposed regulatory change; and

- list and attach all exhibits anticipated to be offered by that person at the hearing, including any proposed statement of reasons for adoption of the rules.

Notices of intent for the hearing must be received in the Office of the Environmental Improvement Board no later than 5:00 p.m. on November 30, 2015 and should reference the name of the regulation, the date of the hearing, and docket number EIB 15-04(R). Notices of intent to present technical testimony should be submitted to:

Pam Castaneda, Administrator of Boards and Commissions
Office of the Environmental Improvement Board
Harold Runnels Building
1190 St. Francis Dr., Room S-2100
Santa Fe, NM 87502

Any person who wishes to do so may offer non-technical public comment at the hearing, or submit a non-technical written statement in lieu of oral testimony at or before the hearing. Written comments regarding the proposed revisions may be addressed to Ms. Pam Castaneda, Administrator of Boards and Commissions, at the above address, and should reference docket number EIB 15-04(R).

If you are an individual with a disability and you require assistance or an auxiliary aid, e.g. sign language interpreter, to participate in any aspect of this process, please contact Juan-Carlos Borrego by November 18, 2015. The Personnel Services Bureau can be reached at the New Mexico Environment Department, 1190 St. Francis Drive, Santa Fe, NM 87502, (505) 827-2844. TDD or TDY users may access this number via the New Mexico Relay Network (Albuquerque TDD users: (505) 275-7333; outside of Albuquerque: 1-800-659-1779 (voice); TTY users: 1-800-659-8331). Copies of the proposed amendments will be available in alternative forms if requested by November 18, 2015.

The Board may make a decision on the proposed regulatory change at the conclusion of the hearing, or the Board may convene a meeting after the hearing to consider action on the proposal.

HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

Notice of Public Hearing

The Human Service Department (HSD) will hold a public hearing to allow public comment on the finalized Federal Poverty Level (FPL) regulations published September 29, 2015. The hearing will be held on Thursday, October 29, 2015, from 9:30 a.m. to 10:30 a.m., at the HSD Income Support Division (ISD) conference room, 2009 S. Pacheco Street, Santa Fe, NM. The conference room is located in Room 120 on the lower level of Pollon Plaza.

New Mexico administers programs according to the Federal Poverty Guidelines of the United States Department of Agriculture (USDA), Food and Nutrition Services (FNS) that are adjusted yearly and effective October 1, 2015.

The Human Services Register Vol. 38 No. 28 outlining the final regulations is available on the HSD's website at: http://www.hsd.state.nm.us/LookingForInformation/income-support-division-registers.aspx. Individuals wishing to testify or to request a copy of the final regulations should contact the Income Support Division, P.O. Box 2348, Pollon Plaza, Santa Fe, NM 87504-2348, or by calling 505-827-1326.

If you are a person with a disability and you require this information in an alternative format, or you require a special accommodation to participate in any HSD public hearing, program, or service, please contact the Assistant General Counsel/American Disabilities Act Coordinator, at 505-827-7720 or through the New Mexico Relay system, at 711 or toll free at 1-800-659-1779. The Department requests at least a 10-day advance notice to provide requested alternative formats and special accommodations.

Individuals who do not wish to attend the hearing may submit written comments which must be received by 5:00 p.m. on the date of the hearing, Thursday, October 29, 2015. Please send comments to:

Human Services Department
P.O. Box 2348, Pollon Plaza
Santa Fe, New Mexico 87504-2348

You may also send comments electronically to: HSD-isdrules@state.nm.us

---

PUBLIC EDUCATION DEPARTMENT

Notice Of Proposed Rulemaking

The New Mexico Public Education Department gives notice that it will conduct a public hearing in Mabry Hall at the Jerry Apodaca Education Building, 300 Don Gaspar Avenue, Santa Fe, New Mexico 87501, on Friday, October 30, 2015, from 10:00 a.m. to noon. The purpose of the public hearing is to receive public input on the proposed repeal and replacement of Title 6 (Primary and

Secondary Education), Chapter 12 (Public School Administration), Part 4 (Tobacco, Alcohol and Drug Free School Districts) of the New Mexico Administration Code, or 6.12.4 NMAC, to: change the part name of the rule to include all public schools; expand the scope of the rule to apply to all school districts and local school boards, and to all state-chartered charter schools and governing bodies; prohibit the use, possession and distribution of tobacco products, e-cigarettes and nicotine liquid containers, alcoholic beverages, mood-altering substances and illicit drugs in public school buildings, on public school premises and by students at school-sponsored activities away from public school grounds; expand the current definitions of the products, beverages, substances, drugs, devices and containers prohibited under the rule; impose new requirements on school boards or governing bodies for the establishment of mandated tobacco, alcohol and drug free school policies; and except from certain provisions of the rule the lawful possession or use by a minor of a tobacco-cessation product approved by the United States Food and Drug Administration.

Interested parties may provide comments on the proposed repeal and replacement of 6.12.4 NMAC at the public hearing or may submit written comments, or both, to Dean Hopper, Director, Coordinated School Health and Wellness Bureau, New Mexico Public Education Department, Room 206, 120 South Federal Place, Santa Fe, New Mexico 87501, or by electronic mail at rule.feedback@state.nm.us, or by facsimile transmission to (505) 827-1826. All written comments must be received no later than 5:00 p.m. (MST) on October 30, 2015. Early submission of written comments is encouraged.

Copies of the proposed rule may be accessed through the New Mexico Public Education Department's website under the "Public Notices" link at http://ped.state.nm.us/ped/PublicNotices.html, or may be obtained from Dean Hopper by contacting him at (505) 827-1806 during ordinary business hours.

Individuals with disabilities who require the above information in an alternative format, or who need any form of auxiliary aid to attend or participate in the public hearing are asked to contact Dean Hopper as soon as possible before the date set for the public hearing. The New Mexico Public Education Department requires at least ten (10) calendar days advance notice to provide any special accommodations requested.

PUBLIC EMPLOYEES RETIREMENT ASSOCIATION

Notice Of P.E.R.A. Rulemaking

The Public Employees Retirement Association ("PERA") will consider changes to its rules promulgated under the Public Employees Retirement Act. Changes are proposed for the following Rules:

Public Employees Retirement
2.80.200 NMAC Organization and Operation of the Public Employees Retirement Board
2.80.2100 NMAC Member Contributions

Copies of the draft rules are available for inspection in PERA's Office of General Counsel. Hard copies of the draft rules may be purchased for $3.00. Written comments, inquiries or requests for copies should be directed to PERA's Office of General Counsel, P.O. Box 2123, Santa Fe, New Mexico, 87504-2123, (505) 476-9353 or 1-800-342-3422. Written comments or requests for copies may be submitted electronically to: LaurieAnn Trujillo at lauriea.trujillo@state.nm.us. To be considered, written comments, arguments, views or relevant data should be submitted by 5:00 p.m. on November 2, 2015. The PERA Board will review and consider all written comments addressing the proposed rule changes.

A formal rulemaking hearing will be held on November 10, 2015 at 9:00 a.m. in the Fabian Chavez Jr. Board Room of the PERA Building, 33 Plaza La Prensa, Santa Fe, New Mexico. Oral comments will be taken at the public hearing. Final action on the rules will occur at the November 2015 monthly meeting of the PERA Board which will be held in the Fabian Chavez Jr. Board Room of the PERA Building, 33 Plaza La Prensa, Santa Fe, New Mexico at a date and time specified in the Board's Public Meeting Notice.

Individuals with a disability who are in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing may contact Judy Olson at (505) 476-9305 or toll free at 1-800-342-3422 seven days prior to the hearing or as soon as possible.

PUBLIC REGULATION COMMISSION

Notice Of Proposed Rulemaking Case No. 15-00264-UT

The Public Regulation Commission ("PRC" or "Commission") gives notice of its initiation of a proposed rulemaking promulgating *revisions to Rule 17.11.10 NMAC concerning the State Rural Universal Service Fund.*
Copies of the Order Initiating Rulemaking containing additional information, a copy of the proposed rule and filing instructions may be downloaded from the Proposed Rulemaking section of the Commission's website at http://www.nmprc.state.nm.us under Case No. 15-00264-UT or by calling the Commission's Records Management Bureau at (505) 827-6968 (Melanie Sandoval) or (505) 827-6970 (Faith Griego).
Written Initial Comments and written Response Comments shall be filed by the deadlines below with the NMPRC's Records Management Bureau at P.O. Box 1269, Santa Fe, NM 87504-1269 or by hand delivery to the NMPRC Records Management Bureau at 1120 Paseo de Peralta, Room 406, Santa Fe, NM 87501 as follows: Written Initial Comments not later than *October 13, 2015* and written Response Comments not later than *October 23, 2015*. Comments shall refer to Case No. 15-00264-UT.
A public hearing will be held on *November 4, 2015, beginning at 1:30 p.m.* at the offices of the Commission located in the 4th Floor Hearing Room of the old PERA Building, at 1120 Paseo de Peralta, in Santa Fe. The purpose of the hearing is to give interested individuals an opportunity to give oral comments. The Commission may limit the time for each comment to five minutes. The record of this case will close on *November 16, 2015.*
Interested persons should contact the Commission to confirm the date, time, and place of this public hearing because hearings are occasionally rescheduled.
Any person with a disability requiring special assistance in order to participate in the hearing should contact Irma Corral at (505) 827-6947 at least 48 hours prior to the commencement of the hearing.
Constitutional and Statutory Authority: New Mexico Constitution, Article XI, Sec. 2; NMSA 1978, Sections 8-8-4(B)(10) (1998), 8-8-15 (1999, amended 2001), 63-9H-4 (1999, amended 2013) and 63-9H-6 (1999, amended 2013).

SECRETARY OF STATE

Notice of Proposed Rulemaking

The NM Secretary of State's Office ("Office") hereby gives notice that the Office will conduct a public hearing at the State Capitol Room 317, 491 Old Santa Fe Trail, Santa Fe, New Mexico 87501, on Friday, October 23, 2015, from 9:00 am to 1:00 pm. The purpose of the hearing is to obtain public input on the following rules:

1) A repeal and replacement of the rule prescribing the order of offices on the ballot, 1.10.11 NMAC.
2) An amendment to the rule for voter records system, 1.10.35 NMAC.
3) A new campaign finance rule, to be codified as 1.10.13 NMAC.

Interested individuals may provide comments at the public hearing and/or submit written comments to Kari Fresquez, Interim Election Director via email at sos.rules@state.nm.us, fax (505)827-8081, or mail at Attn: Kari Fresquez – proposed rule, Secretary of State, 325 Don Gaspar, Suite 300, Santa Fe, NM 87501.

Written comments must be received no later than 5:00 pm on the date prior to the hearing. However, the submission of written comments as soon as possible is encouraged. Copies of the proposed rules are available on the Office's website at www.sos.state.nm.us or obtained from Ms. Fresquez by calling (505) 827-3600.

Individuals with disabilities who require this information in an alternative format or need any form of auxiliary aid to attend or participate in the public hearing are asked to contact Ms. Fresquez as soon as possible to provide requested special accommodations.

WORKERS' COMPENSATION ADMINISTRATION

Notice of Public Hearing

The New Mexico Workers' Compensation Administration will conduct a public hearing on changes to the New Mexico Health Care Provider Fee Schedule on:

Thursday, October 22, 2015
1:30 p.m.
Workers' Compensation Administration
2410 Centre Avenue S.E., Albuquerque, NM 87106

Copies of the proposed changes to the fee schedule will be available on October 1, 2015. Written comments on the rule changes will be accepted until the close of business on October 30, 2015.

Copy of the proposed changes may be found at the WCA website at: http://www.workerscomp.state.nm.us/.

Comments made in writing and at the public hearing will be taken into consideration. Oral comments may be limited to five (5) minutes per speaker. Comments should be submitted to the WCA Economic Research Bureau, Post Office Box 27198, Albuquerque, NM 87125-7198.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any form of auxiliary aide or service to attend or participate in the hearing or meetings, please contact the General Counsel Office at (505) 841-6083. Or you may inquire about assistance through the New Mexico relay network at 1-800-659-8331.

DEPARTMENT OF WORKFORCE SOLUTIONS

Notice of Public Hearing

The New Mexico Department of Workforce Solutions ("Department") hereby gives notice that the Department will conduct a public hearing in the auditorium of the State Personnel Office located at 2600 Cerrillos Road, Santa Fe, New Mexico on October 30, 2015 from 2:00 P.M. until 4:00 P.M. The purpose of the public hearing will be to obtain input on the adoption of the proposed prevailing wage and fringe benefit rates for public works projects pursuant to 11.1.2.13. NMAC.

Interested individuals may testify at the public hearing or submit written comments to State of New Mexico Department of Workforce Solutions, 401 Broadway NE, P.O. Box 1928, Albuquerque, N.M., 87103, attention Rudolph Arnold. Written comments must be received no later than 5 P.M. on October 30, 2015. However, the submission of written comments as soon as possible is encouraged.

Copies of the proposed prevailing wage and fringe benefit rates may be accessed at http://www.dws.state.nm.us/ or obtained from Rudolph Arnold, telephone number: (505) 841-8672 rudolph.arnold@state.nm.us. The proposed prevailing wage and fringe benefit rates will be made available at least thirty days prior to the hearings.

Individuals with disabilities who require this information in an alternative format or need any form of auxiliary aid to attend or participate in this meeting are asked to contact Mr. Rudolph Arnold as soon as possible. The Department requests at least ten (10) days advance notice to provide requested special accommodations.

End of Notices of Rulemaking and Proposed Rules

This Page Intentionally Left Blank

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.

CHILDREN, YOUTH AND FAMILIES DEPARTMENT

The Children, Youth and Families Department at its hearing on 8/27/2015, repealed it rule 8.10.3 NMAC, Protective Services Investigation, filed 3/31/2010, and replaced it with 8.10.3 NMAC, Protective Services Investigation, effective 9/29/15.

The Children, Youth and Families Department at its hearing on 9/9/2015, repealed it rule 8.10.8 NMAC, Permanency Planning, filed 11/15/2005, and replaced it with 8.10.8 NMAC, Permanency Planning, effective 9/29/15.

CHILDREN, YOUTH AND FAMILIES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 10 CHILD PROTECTIVE SERVICES
PART 3 PROTECTIVE SERVICES INVESTIGATION

8.10.3.1 ISSUING AGENCY: Children, Youth and Families Department (CYFD), Protective Services Division (PSD)
[8.10.3.1 NMAC - Rp, 8.10.3.1 NMAC, 09/29/15]

8.10.3.2 SCOPE: Protective services employees and the general public.
[8.10.3.2 NMAC - Rp, 8.10.3.2 NMAC, 09/29/15]

8.10.3.3 STATUTORY AUTHORITY: Children, Youth and Families Department Act, Section 9-2A-7 D, NMSA 1978; New Mexico Children's Code, Section 32A-1-1, NMSA 1978 (2009 Cum. Supp.)
[8.10.3.3 NMAC - Rp, 8.10.3.3 NMAC, 09/29/15]

8.10.3.4 DURATION: Permanent.
[8.10.3.4 NMAC - Rp, 8.10.3.4 NMAC, 09/29/15]

8.10.3.5 EFFECTIVE DATE: September 29, 2015, unless a later date is cited at the end of a section.
[8.10.3.5 NMAC - Rp, 8.10.3.5 NMAC, 09/29/15]

8.10.3.6 OBJECTIVE: To establish guidelines for the investigation and disposition of cases of alleged abuse and neglect of children by their parent, guardian, other household members or foster care provider.
[8.10.3.6 NMAC - Rp, 8.10.3.6 NMAC, 09/29/15]

8.10.3.7 DEFINITIONS:

A. "Abandonment" as defined in the Children's Code, Section 32A-4-2(A) NMSA 1978, includes instances when the parent, without justifiable cause:

(1) left the child without provision for the child's identification for a period of 14 days; or

(2) left the child with other, including the other parent or an agency, without provision for support and without communication for a period of:

(a) three months if the child was under six years of age at the commencement of the three month period; or

(b) six months if the child was over six years of age at the commencement of the six month period.

B. "Abused child" as defined in the Children's Code, Section 32A-4-2(B) NMSA 1978, means a child:

(1) who has suffered or who is at risk of suffering serious harm because of the action or inaction of the child's parent, guardian or custodian;

(2) who has suffered physical abuse, emotional abuse or psychological abuse inflicted or caused by the child's parent, guardian or custodian;

(3) who has suffered sexual abuse or sexual exploitation inflicted by the child's parent, guardian or custodian;

(4) whose parent, guardian or custodian has knowingly, intentionally or negligently placed the child in a situation that may endanger the child's life or health; or

(5) whose parent, guardian or custodian has knowingly or intentionally tortured, cruelly confined or cruelly punished the child.

C. "Administrative hearing" means a formal process in which the client shall have an opportunity to present evidence to an impartial hearing officer in accordance with CYFD's administrative appeals regulations 8.8.4 NMAC.

D. "Administrative review" is an informal process which may include an informal conference or a record review, and does not create any substantive rights for the family.

E. "Accepted report" is a verbal or written presentation of information concerning the alleged abuse or neglect made to the protective services division (PSD) of child abuse or neglect that falls within PSD's legal authority to investigate.

F. "Children's Code" refers to the New Mexico State Statute, Chapter 32A NMSA 1978.

G. "Child vulnerability" refers to the child's ability to protect him or herself from identified safety threats as well as the child's ability to care for him or herself when the child's parent or guardian is not able to meet the child's basic needs.

H. "Collateral contact" refers to any person who may be able to provide information to the PSD worker during an investigation of alleged abuse or neglect, concerning the alleged abuse or neglect that would be helpful in assessing child vulnerabilities, safety threats and parent or guardian protective capacities.

I. "Conditionally safe" means that one or more safety threats have been identified that places the child in present or impending danger of serious harm, however one or more protective capacities has been identified to offset, mitigate or control the threat of present or impending danger of serious harm.

J. "Custodian" as defined in the Children's Code, Section

32A-1-4(E) NMSA 1978, means an adult with whom the child lives who is not a parent or guardian of the child.

K. "CYFD" refers to the New Mexico children, youth and families department.

L. "Exigent circumstances" means when there is credible information that a child is in danger of severe harm and requires immediate protective services.

M. "Emotional maltreatment" is an observable behavior, activity, or words to intimidate, threaten, deride or degrade the child that causes substantial impairment of the child's mental or psychological ability to function.

N. "FACTS" refers to the family automated client tracking system (FACTS), the official data management system for CYFD.

O. "Guardian" as defined in the Children's Code, Section 32A-1-4(I) NMSA 1978, means a person appointed as guardian by a court or Indian tribal authority or a person authorized to care for the child by a parental power of attorney as permitted by law.

P. "Home school" is the operation of a home study program by a parent as filed with the public education department.

Q. "Impending danger" is when a child is living in a state of danger or position of continual danger due to a family circumstance or behavior. The threat caused by the circumstance or behavior is not presently occurring, but it can be anticipated to have severe effects on a child at any time.

R. "Indian child" means any unmarried person who is under age 18 and is either a member of an Indian tribe, or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.

S. "Initiation" of an investigation is the face-to-face contact by a PSD worker with the alleged victim, or documented diligent efforts to establish face-to-face contact with the victim.

T. "Investigative decision" is a determination of whether each allegation in the report is substantiated or unsubstantiated, as defined herein at 8.10.3.17 NMAC.

U. "Investigation disposition" is the determination of the level of involvement, if any, of PSD with the family based upon an assessment of safety threats and protective capacities, and considering the ongoing risk to the child and the needs and strengths of the family.

V. "Neglected child" as defined in the Children's Code, Section 32A-4-2(E) NMSA 1978, means a child:

(1) who has been abandoned by the child's parent, guardian or custodian;

(2) who is without proper parental care and control or subsistence, education, medical or other care or control necessary for the child's well-being because of faults or habits of the child's parent, guardian or custodian, or the failure or refusal of the parent, guardian or custodian, when able to do so, to provide them;

(3) who has been physically or sexually abused, the child's parent, guardian or custodian knew or should have known of the abuse and failed to take reasonable steps to protect the child from further harm;

(4) whose parent, guardian or custodian is unable to discharge that person's responsibilities to and for the child because of incarceration, hospitalization or physical or mental disorder or incapacity; or

(5) who has been placed for care of adoption in violation of the law; provided that nothing in the Children's Code shall be construed to imply that a child who is being provided with treatment by spiritual needs alone through prayer, in accordance with the tenets and practices of a recognized church or religious denomination, by a duly accredited practitioner thereof is for that reason alone a neglected child within the meaning of the Children's Code; and further provided that no child shall be denied the protection afforded to all children under the Children's Code.

W. "Parent" as defined in the Children's Code, Section 32A-1-4(P) NMSA 1978, includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child.

X. "Parental notice or notification" is an in-person or telephone notice to the parent or legal guardian that his or her child will be or has been interviewed as part of an investigation.

Y. "Permission" is the consent for the child to participate in an investigation.

Z. "Physical abuse" as defined in the Children's Code, Section 32A-4-2(F) NMSA 1978 includes, but is not limited to any case in which the child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling or death and:

(1) there is not a justifiable explanation for the condition or death;

(2) the explanation given for the condition is at variance with the degree or nature of the condition;

(3) the explanation given for death is at variance with the nature of the death; or

(4) circumstances indicate that the condition or death may not be the product of an accidental occurrence.

AA. "Placement" is an out of home residential arrangement for the care of children in PSD custody, which may include, but is not limited to family foster care, relative foster care and treatment foster care, or a facility such as residential treatment center, group home, or emergency shelter.

BB. "Present danger" means immediate, significant and observable severe harm or threat of immediate and severe harm that is presently occurring to a child and requires an immediate protective services response.

CC. "Protective capacities" are those assets possessed by the parent or guardian that help reduce, control or prevent present or impending danger of serious harm to a child.

DD. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

EE. "Provider" refers to a person or agency providing services to a PSD client.

FF. "Private school" is a public education department authorized school, including private childcare, other than a home school, that is not under the control, supervision or management of a local school board.

GG. "PSD custody" means custody of children as a result of an action occurring pursuant to the Children's Code, 32A-4 NMSA 1978 or 32A-3B and 34A-4 NMSA 1978.

HH. "PSD worker" refers to a person employed by the children, youth and families department, protective services division.

II. "Public school" is a school that is under the control, supervision or management of a local school district or the state board of education, including charter schools.

JJ. "Reasonable efforts" as used in this policy refers to the provision of services or other interventions to prevent the removal of

the child from the home, or if removal is required, to return the child home as soon as possible.

KK. **“Report”** is a verbal or written presentation of information alleging child abuse or neglect that is received by an intake worker.

LL. **“Risk”** is the term used to describe PSD’s assessment, based on established criteria, of the likelihood that child will be abused or neglected by his or her parents or legal guardians.

MM. **“Safe”** as used in this policy means that there are no safety threats placing the child in a present or impending danger of serious harm.

NN. **“Safe Haven for Infants Act”** means an Act, Section 24-22-1 NMSA 1978, to promote the safety of infants and to immunize a parent from criminal prosecution for leaving an infant, 90 days of age or less, at a safe haven site. This Act is not intended to abridge the rights or obligations created by the federal Indian Child Welfare Act of 1978 or the rights of the parents.

OO. **“Safe haven site”** as defined by Section 24-22-2 (F) NMSA 1978 means a hospital, law enforcement agency, or fire station that has staff onsite at the time an infant, 90 days of age or less, is left at such site.

PP. **“Safety decision”** is based on the presence of safety threats and protective capacities that offset, mitigate or control those threats. A child may be assessed to be safe, conditionally safe or unsafe.

QQ. **“Safety plan”** is a document that identifies the strategy or group of strategies implemented to control a safety threat. It is an intrusion into family life in the form of ongoing assessment and specific strategies designed to match the duration and level of the safety threat up to and including removal of the child from home.

RR. **“Safety threats”** are threats of serious harm to a child that may create a present or impending danger.

SS. **“Sexual abuse”** as defined in the Children’s Code, Section 32A-4-2(G) NMSA 1978, includes but is not limited to criminal sexual contact, incest or criminal sexual penetration, as those acts are defined by state law.

TT. **“Sexual exploitation”** as defined in the Children’s Code, Section 32A-4-2(H) NMSA 1978 includes, but is not limited to:

(1) allowing, permitting or encouraging a child to engage in prostitution;

(2) allowing, permitting or encouraging a child in obscene or pornographic photographing; or

(3) filming or depicting a child for obscene or pornographic commercial purposes, as those acts are defined by state law.

UU. **“Statewide central intake (SCI)”** is the unit within PSD whose responsibilities may include, but is not limited to receiving and screening reports of alleged child abuse or neglect and prioritizing and assigning accepted reports to the appropriate county office for investigation.

VV. **“Unsafe”** means that one or more safety threats have been identified that place the child in present or impending danger of serious harm and there are not sufficient protective capacities to offset, mitigate or control the threat of present or impending danger of serious harm.

WW. **“Witness” ”** refers to a person who has a firsthand account of an event that is relevant to a PSD abuse and neglect investigation.

[8.10.3.7 NMAC - Rp, 8.10.3.7 NMAC, 09/29/15]

8.10.3.8 PURPOSE OF CHILD PROTECTIVE SERVICES INVESTIGATION:

A. The purpose of protective services investigation is to assess safety of children who are the subjects of reports of alleged abuse or neglect by:

(1) collecting and assessing information to determine whether the alleged child abuse or neglect occurred;

(2) determining whether any child in the home is vulnerable to present or impending danger:

(3) assessing the parent or guardian protective capacities; and

(4) determining the need for additional services.

B. Investigations shall be conducted for children in the custody of their biological parents, adoptive parents, guardians, or custodians and for children in PSD custody.

C. Reports of child abuse or neglect in schools, facilities, and childcare homes or centers shall be investigated by a local law enforcement agency. See 8.10.3.13 NMAC.

[8.10.3.8 NMAC - Rp, 8.10.3.8 NMAC, 09/29/15]

8.10.3.9 ASSIGNMENT AND INITIATION OF INVESTIGATION:

A. Every accepted report concerning alleged child abuse or neglect shall be assigned for investigation according to the investigation priority as determined by statewide central intake (SCI).

B. Investigation priority: The PSD worker shall initiate the investigation within the time frames established by PSD as follows:

(1) An emergency report requires than an investigation be initiated within three hours of the SCI supervisor’s screening decision.

(2) A priority one report requires than an investigation be initiated within 24 hours of the SCI supervisor’s screening decision.

(3) A priority two report requires than an investigation be initiated within five calendar days of the SCI supervisor’s screening decision.

C. In cases when there has been a child fatality, the PSD worker shall not be required to make face to face contact with the deceased alleged victim for purposes of the initiation of the investigation.

[8.10.3.9 NMAC - Rp, 8.10.3.9 NMAC, 09/29/15]

8.10.3.10 INVESTIGATION REQUIREMENTS - GENERAL:

A. The safety of the child is the overriding concern throughout the casework relationship with the family. If the safety of the child is ever in conflict with the preservation of a family unit, the child’s need for protection always takes precedence. PSD shall request immediate assistance from law enforcement if necessary to assess and secure the safety of the child.

B. The PSD worker shall conduct the investigation in a manner that protects the privacy of the child and family.

C. The PSD worker shall make efforts to engage the family in the investigation and assessment process to gather the information required to identify the safety threats, child vulnerabilities, protective capacities and ongoing risks of harm to the child.

D. The PSD worker shall interview collateral contacts during the investigation.

E. The PSD worker shall visit the home during an investigation. This requirement may be waived in specific circumstances that include but are not limited to:

(1) the parent, guardian or custodian refuses the worker

entrance;

(2) the home has been determined to be unsafe by law enforcement or public health; or

(3) the family is homeless.

F. The PSD worker shall complete the New Mexico child safety assessment and risk assessment tools in all investigations. These are FACTS tools used by the PSD worker in determining the investigation disposition.

G. The PSD worker shall make efforts to provide or arrange for services for the child and family during the investigation to enhance the family's capacity to safely care for their child.

[8.10.3.10 NMAC - Rp, 8.10.3.10 NMAC, 09/29/15]

8.10.3.11 INVESTIGATION REQUIREMENTS - CHILD VICTIM AND OTHER CHILDREN:

A. The PSD worker shall interview and observe the alleged child victim and all other children in the household during the investigation. A parent, guardian or custodian may refuse the PSD worker permission to interview or observe the child. If access is denied, the PSD worker shall determine whether it is necessary to contact law enforcement or obtain a court order to ensure the safety of the child. The following applies based on the site at which the interview will take place.

(1) Interviews at home: Children contacted at home shall be interviewed only with the permission of the parent, guardian or custodian.

(2) Interviews at public schools: Public schools are required by the Children's Code, Section 32A-4-5 (C) NMSA 1978, to permit the PSD worker to interview children involved in a PSD investigation without obtaining the permission of the parent of guardian.

(3) Interviews at private schools or in childcare homes and facilities:

(a) a private school or childcare home or facility may deny permission for the PSD worker to interview the child on the facility grounds, and

(b) if permission is denied by the private school or childcare home and by the parent, guardian or custodian and exigent circumstances are believed to exist, PSD shall determine whether to contact law enforcement or obtain a court order.

B. The PSD worker shall conduct all interactions with alleged child victims and child witnesses in a child sensitive manner that takes into consideration the special needs of the child, the child's ability, age, language and intellectual maturity and protects the child's privacy.

C. The PSD worker shall inform all children that their participation in the interview is voluntary. Children 14 years of age and older must agree to participate in the interview even when the PSD worker has obtained permission from the parent, guardian, or custodian.

D. The PSD worker shall arrange for any medical, mental health, or other evaluations or examinations as required during the investigation. Consent is required from the parent, guardian or custodian for any non-emergency medical, mental health or other evaluations, examinations or assessments. Children 14 years of age or older must also consent to services.

[8.10.3.11 NMAC - Rp, 8.10.3.11 NMAC, 09/29/15]

8.10.3.12 INVESTIGATION REQUIREMENTS - PARENTS AND GUARDIANS:

A. The PSD worker shall notify the parent, guardian or custodian of the interview with the child in advance of the interview unless the worker has determined that notification could adversely affect the safety of the child about whom the report has been made or compromise the investigation.

B. If the PSD worker determines that notification could adversely affect the safety of the child or compromise the investigation, the worker may interview a child without prior notification to the parent, guardian, or custodian. In this situation, the PSD worker shall notify the parents or guardians of the interview within 24 hours.

C. The PSD worker shall identify all legal guardians of the child.

D. The PSD worker shall interview the parent, guardian or custodian and collateral contacts or witnesses during the investigation.

E. At the time of initial contact with the parents, guardian or alleged perpetrator the PSD worker shall inform him or her of the reported allegations in a manner consistent with laws protecting the rights of the reporter.

F. At the beginning of the investigation, or prior to beginning an interview with the parent or guardian, the PSD worker shall inform the parents or guardians of the following:

(1) that prior to filing an abuse and neglect petition any PSD interaction with the parents or guardians, is voluntary;

(2) that PSD has received a report alleging child abuse or neglect and the nature of the allegations;

(3) that PSD is required by law to conduct an investigation of screened-in reports;

(4) that only law enforcement can remove a child who is not in PSD custody, if necessary to protect the child's health and safety, unless the district court issues an ex parte order allowing PSD to remove the child;

(5) that the investigation findings, decision, and disposition are confidential in accordance with the Children's Code, Section 32A-4-33 NMSA 1978;

(6) that information concerning the report and investigation has been entered into FACTS;

(7) that other people may be interviewed in order to complete the investigation; and

(8) children age 14 and older may consent to an interview away from the home even when the parent does not consent.

G. The PSD worker shall provide the parent, guardian or custodian with information regarding CYFD's complaint process should the parent or guardian have any complaints.

[8.10.3.12 NMAC - Rp, 8.10.3.12 NMAC, 09/29/15]

8.10.3.13 ALLEGATIONS OF ABUSE OR NEGLECT IN FACILITIES:

A. Law enforcement shall be responsible for conducting investigations of child abuse or neglect in schools, facilities and child care homes or centers. Upon request from law enforcement, PSD shall assist in the investigation.

B. When PSD is notified of any allegations in a school, facility or child care home or center in which a child in PSD custody is placed or receiving services:

(1) if the alleged victim is a child in PSD custody, PSD shall conduct an assessment of that child's safety and well-being; or

(2) if the alleged victim is not a child in PSD custody, PSD may, at its discretion, conduct an assessment of the safety and well-being of any children in PSD custody placed or receiving services there.

[8.10.3.13 NMAC - Rp, 8.10.3.13 NMAC, 09/29/15]

8.10.3.14 ALLEGATIONS OF ABUSE OR NEGLECT IN FOSTER HOMES, TREATMENT FOSTER HOMES, AND PRE-ADOPTIVE HOMES:

A. PSD shall investigate abuse or neglect allegations involving a PSD licensed foster home, treatment foster home, or pre-adoptive home.

B. PSD shall notify law enforcement and coordinate the investigation with law enforcement when law enforcement is involved.

[8.10.3.14 NMAC - Rp, 8.10.3.14 NMAC, 09/29/15]

8.10.3.15 INVESTIGATIONS INVOLVING INDIAN CHILDREN:

A. PSD shall investigate allegations of child abuse or neglect involving Indian children who reside off the reservation or pueblo.

B. PSD may assist in the investigation of allegations of child abuse or neglect involving children who reside on the reservation or pueblo, if requested by the Indian tribal government.

C. PSD shall make efforts to determine if the child who is subject of an investigation is an Indian child.

D. PSD shall notify the appropriate tribal authority of any investigations involving Indian children.

[8.10.3.15 NMAC - Rp, 8.10.3.15 NMAC, 09/29/15]

8.10.3.16 SEEKING OR ACCEPTING CUSTODY OF CHILDREN, INCLUDING INDIAN CHILDREN:

A. PSD shall make reasonable efforts to maintain the family unit and prevent the removal of a child from his or her home, as long as the child's safety is assured.

B. If temporary out-of-home placement is necessary to ensure the immediate safety of the child, PSD shall make reasonable efforts to effect the safe reunification of the child and family.

C. PSD shall seek custody of Indian children who are domiciled or residing off-reservation when continued custody of the child by the parent, guardian or custodian or Indian custodian is likely to result in serious emotional or physical harm to the child.

D. An Indian child who is domiciled on the reservation but temporarily located off the reservation may be removed by law enforcement from his parent, guardian or custodian in order to prevent imminent physical harm to the child. PSD shall notify the tribe as soon as possible and facilitates a transfer of the case to the tribe.

E. PSD shall notify the parent, guardian or custodian that their child is in custody within 24 hours of the child being taken into custody.

F. PSD shall make reasonable efforts to identify, locate and notify appropriate relatives for consideration of placement of a child in custody who requires out of home placement.

G. When a law enforcement agency seeks to place a child in the custody of PSD, then the PSD worker shall obtain a statement of reasonable grounds for temporary protective services division custody from the law enforcement officer making the request.

H. When SCI receives a report that an infant has been left under the provisions of the Safe Haven for Infants Act, the children, youth and families department through its protective services division shall be deemed to have emergency custody of that infant. A law enforcement investigation and 48 hour hold is not required.

[8.10.3.16 NMAC - Rp, 8.10.3.16 NMAC, 09/29/15]

8.10.3.17 COMPLETION OF AN INVESTIGATION AND INVESTIGATION DECISION:

A. The PSD worker shall complete the investigation and decide whether the report's allegations of abuse or neglect are substantiated or unsubstantiated within 45 days of SCI accepting the report for investigation, unless an extension is approved by the supervisor. Extensions are not to exceed an additional 30 days after the original 45 days have passed. Completion of the investigation includes, but is not limited to making the investigation decision, determining the investigation disposition and completing, sending out the notice of results of the investigation letter to the parent or guardian and completing all documentation in FACTS.

(1) **Substantiated report:** an allegation of child abuse or neglect in which a parent, guardian, foster parent, pre-adoptive parent or treatment foster care parent has been identified as the perpetrator or as failing to protect the child and credible evidence exists to support the investigation worker's conclusion that the child has been abused or neglected, as defined in the Children's Code. Credible evidence upon which to base a finding of substantiation may include, but is not limited to:

(a) admission by the parent, guardian or custodian;

(b) physical evidence;

(c) collateral or witness statements and observations;

(d) a child's disclosure;

(e) a child born drug exposed or affected due to illegal or illicit drug use; or

(f) the investigation worker's observations.

(2) **Unsubstantiated report:** an allegation of child abuse or neglect in which the information collected during the investigation does not support a finding that the child was abused or neglected, as defined in the Children's Code by a parent, guardian, foster parent, pre-adoptive parent or treatment foster parent, or that such a person failed to protect the child from abuse or neglect as defined by the Children's Code.

B. When there is clear evidence that a child has been abused or neglected while in the custody of the parent, guardian or custodian, but there is unclear information about who was the perpetrator, then the PSD worker shall substantiate the investigation on an unknown perpetrator. In addition to substantiation on the unknown perpetrator, the PSD worker shall substantiate the investigation on the parent, guardian or custodian because of the failure to protect the child by the parent, guardian or custodian.

C. The PSD worker shall document the investigation decision and the supervisory review and approval of the decision in FACTS within 45 days of the date the report was accepted by SCI, or if an extension was granted, by the end of the extension period.

[8.10.3.17 NMAC - Rp, 8.10.3.17 NMAC, 09/29/15]

8.10.3.18 FAMILIES WITH MORE THAN TWO INVESTIGATIONS: Any family that has been subject to a PSD abuse or neglect investigation, regardless of the decision to substantiate or un-substantiate, shall receive a higher level of case review upon the family's third instance of being investigated by PSD for alleged child abuse or neglect.

[8.10.3.18 NMAC - N, 09/29/15]

8.10.3.19 INVESTIGATION DISPOSITION:

A. PSD shall make an investigation disposition within 45 days of SCI accepting the report in every investigation PSD conducts, unless an extension is approved by the supervisor. Extensions are not to exceed an additional 30 days after the original 45 days have passed.

B. PSD shall determine the disposition of the investigation based upon the safety decision (safe, conditionally safe, or unsafe) and whether a safety plan is required, the family's willingness to participate in services, and the assessment of risk.

C. Disposition options may include, but are not limited to closing the case, referring the family to community providers, providing in-home services (IHS), or referring the case to PSD legal for possible legal action.

D. PSD shall document the investigation disposition in FACTS and include the investigation disposition in the notice of results of investigation letter sent to the parent or guardian.

[8.10.3.19 NMAC - Rp, 8.10.3.18 NMAC, 09/29/15]

8.10.3.20 CHILD FATALITY INVESTIGATION WITH NO OTHER CHILDREN IN THE HOME: PSD shall conduct an investigation of alleged child abuse or neglect resulting in a child fatality when there are no other remaining children residing in the home.

[8.10.3.20 NMAC - Rp, 8.10.3.19 NMAC, 09/29/15]

8.10.3.21 DOCUMENTATION:

A. PSD shall document investigation assignments and requirements, as described herein at 8.10.3.9, 8.10.3.10, 8.10.3.11, and 8.10.3.12 NMAC, and shall document the investigation decision, disposition and notice of results of the investigation letter in FACTS as described herein at 8.10.3.17 and 8.10.3.19 NMAC.

B. PSD shall document reasonable efforts made to prevent removal of a child from the home and efforts to reunify the child if removal was required during the investigation. Documentation shall be included in the case record and in the affidavit for custody.

C. All information obtained by PSD in an abuse and neglect investigation is confidential and may not be publically released. (See Protective Services General Policies, Subsection A of 8.8.2.15 NMAC).

[8.10.3.21 NMAC - Rp, 8.10.3.20 NMAC, 09/29/15]

8.10.3.22 NOTIFICATION OF THE INVESTIGATIVE DECISION AND RIGHT TO ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING:

A. The PSD worker shall provide parents, guardians, foster parents, pre-adoptive parents and treatment foster parents who were the subject of the investigation the notice of results of the investigation letter. The PSD worker shall send the notice of the results of the investigation letter within the 45 day time frame, or with a possible 30 day extension. (See above at Subsection A of 8.10.3.17 NMAC).

B. The PSD worker shall notify parents, guardians, foster parents, pre-adoptive parents and treatment foster parents who were the subject of a substantiated investigation, which is not the subject of a pending children's court case, in writing that the decision to substantiate the investigation may be reviewed through PSD's administrative review process. A client seeking an administrative review shall request the review in writing to PSD within 10 days of the action or notice of the proposed action.

C. If the investigation decision is upheld after being reviewed through PSD's administrative review process, then PSD shall send a formal letter to the parent, guardian, foster parent, pre-adoptive parent or treatment foster parent, who was the subject of the investigation, notifying them of the decision to uphold the substantiation and that the upheld decision may be reviewed through CYFD's administrative hearing process. The parent, guardian, foster parent, pre-adoptive parent or treatment foster parent shall request an administrative hearing in writing to the PSD director's office within 10 days of receipt of the letter.

[8.10.3.22 NMAC – Rp; 8.10.3.21 NMAC, 09/29/15]

8.10.3.23 CHILD PROTECTIVE SERVICES CHILDCARE DURING THE CPS INVESTIGATION: The PSD worker may offer child protective services childcare during an open investigation as part of an in home safety plan created for the child. Child protective services childcare may be provided during the investigation within the 45 day time frame, or with possibility of a 30 day extension, given to complete the investigation. (See above at Subsection A of 8.10.3.17 NMAC.)

[8.10.3.23 NMAC – Rp; 8.10.3.22 NMAC, 09/29/15]

HISTORY OF 8.10.3 NMAC:

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

SSD Rule #410.0000, Protective Services to Children, filed 11-10-81;
SSD 4.0.0, Child Protective Services - Definition and Goal Statement, filed 8-22-86;
SSD 4.0.0, Child Protective Services - Definition and Goal Statement, filed 3-28-89;
SSD 4.1.0, Child Protective Services - General Provisions, filed 8-22-86;
SSD 4.1.0, Child Protective Services - General Provisions, filed 1-29-87;
SSD 4.1.0, Child Protective Services - General Provisions, filed 6-18-87;
SSD 4.1.0, Child Protective Services - General Provisions, filed 3-28-89;
SSD 4.1.0, Child Protective Services - General Provisions, filed 9-14-89;
SSD 4.1.0, Child Protective Services - General Provisions, filed 9-18-90;
SSD 4.2.0, Child Protective Services - General Guidelines, filed 8-22-86;
SSD 4.2.0, Child Protective Services - General Guidelines, filed 3-28-89;
SSD 4.3.0, Child Protective Services - Department Responsibilities, filed 8-22-86;
SSD 4.3.0, Child Protective Services - Department Responsibilities, filed 11-18-87;
SSD 4.3.0, Child Protective Services - Department Responsibilities, filed 6-13-88;
SSD 4.3.0, Child Protective Services - Department Responsibilities, filed 3-28-89;
SSD 4.3.0, Child Protective Services - Department Responsibilities, filed 3-20-90;
SSD 4.3.0, Child Protective Services - Department Responsibilities, filed 9-18-90.

History of Repealed Material:

8 NMAC 10.3, Child Protective Services Investigation, filed 6/16/97 - Repealed effective 2/14/01.
8.10.3 NMAC, Child Protective Services Investigation, filed 2/1/01 - Repealed effective 7/30/04.
8.10.3 NMAC, Child Protective Services Investigation, filed 7/16/04 - Repealed effective 11/15/05.

8.10.3 NMAC, Child Protective Services Investigation, filed 11/1/05 - Repealed effective 6/15/06.
8.10.3 NMAC, Protective Services Investigation, filed 5/31/06 - Repealed effective 3/31/10.
8.10.3 NMAC, Protective Services Investigation, filed 3/31/10 - Repealed effective 9/29/15.

CHILDREN, YOUTH AND FAMILIES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 10 CHILD PROTECTIVE SERVICES
PART 8 PERMANENCY PLANNING

8.10.8.1 ISSUING AGENCY: Children, Youth and Families Department, Protective Services Division.
[8.10.8.1 NMAC - Rp, 8.10.8.1 NMAC, 09/29/15]

8.10.8.2 SCOPE: Protective services employees and the general public.
[8.10.8.2 NMAC - Rp, 8.10.8.2 NMAC, 09/29/15]

8.10.8.3 STATUTORY AUTHORITY: New Mexico Children's Code, Section 32A-1-1, NMSA 1978 (Repl. 2004).
[8.10.8.3 NMAC - Rp, 8.10.8.3 NMAC, 09/29/15]

8.10.8.4 DURATION: Permanent.
[8.10.8.4 NMAC - Rp, 8.10.8.4 NMAC, 09/29/15]

8.10.8.5 EFFECTIVE DATE: September 29, 2015, unless a later date is cited at the end of a section.
[8.10.8.5 NMAC - Rp, 8.10.8.5 NMAC, 09/29/15]

8.10.8.6 OBJECTIVE: To establish parameters for the provision of permanency planning services to children in the custody of CYFD.
[8.10.8.6 NMAC - Rp, 8.10.8.6 NMAC, 09/29/15]

8.10.8.7 DEFINITIONS:
A. "Case plan" means a plan created jointly with clients for a child, youth, parent, guardian, custodian or respondent that identifies the appropriate services based on the needs identified to achieve the child's or youth's permanency plan and to promote the safety and well-being of each child or youth.
B. "Close proximity" means a location physically close enough to facilitate family visiting, consistent with the best interest and identified needs of the child.
C. "Community home" means a home which operates 24 hours a day and provides full time care, supervision and support to no more than 16 children in a single residential building, and which meets the definition of "group home" as outlined in the Human Services Department Act, Section 9-8-13 NMSA 1978.
D. "Concurrent plan" means a second permanency plan of adoption or guardianship in addition to the primary permanency plan of reunification.
E. "Conditionally safe" means that one or more safety threats have been identified that places the child in present or impending danger of serious harm, however one or more protective capacities has been identified to offset, mitigate or control the threat of present or impending danger of serious harm.
F. "CYFD" refers to the New Mexico children, youth and families department.
G. "Early and periodic screening, diagnosis and treatment (EPSDT)", is a medicaid program designed to provide comprehensive and preventive health care services to medicaid-eligible children under age 21.
H. "Fictive kin" means a person not related by birth, adoption or marriage with whom the child has an emotionally significant relationship.
I. "Foster care provider" refers to a person or entity licensed by CYFD, licensed by another state's child welfare agency, or a licensed child placement agency to provide foster care services including respite, non-relative, relative, or treatment foster care.
J. "Foster child" as referred to as "child" herein, means a child who is placed in the care and custody of children, youth and families department protective services division either under the legal authorization of the Children's Code or through a voluntary placement agreement signed by the parent or legal guardian, or a child who is placed with a licensed child placement agency under the authority of the Child Placement Agency Licensing Act. If the court orders legal custody to a relative, person, facility, or agency other than the children, youth and families department protective services division, the child is not a foster child of protective services division.
K. "Foster home license" is the document which bears the name or names and address or addresses of those who are foster parents for the protective services division or licensed child placement agency. The license displays the ages and number of foster children the licensees are authorized to care for and the date such authorization begins and ends. The license shall bear the signature of the authorized person who issued the license.
L. "Foster parent" is the person named on the license issued by protective services division or a licensed child placement agency who is authorized to care for foster children. Throughout this policy, the term foster parent also refers to an adoptive parent whose adoption has not yet finalized.
M. "Indian child" means any unmarried person who is under age 18 and is either a member of an Indian tribe, or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.
N. "Maintenance payments" are payments designed to reimburse foster care providers for the cost of food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, and reasonable travel required to address the child's needs. Maintenance payments are not considered income.
O. "New Mexico Children's Code" refers to Section 32A-1-1 NMSA 1978.
P. "Needs" may refer to services and supports to address safety and the physical and emotional well-being of the child, parent, guardian, or foster parent. Needs may also include activities that promote the normalcy of the child.
Q. "Parent" " as defined in the Children's Code, Section 32A-1-4(P) NMSA 1978, includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child.
R. "Permanency planning" is the systematic process of carrying out, within a time-limited period, a set of goal directed activities designed to help children live in families that offer continuity of relationships with nurturing parents or legal guardians and the opportunity to establish healthy and positive lifetime relationships that are in the best interest of the child or youth.
S. "Protective services division (PSD)" refers to the protective services division of the children, youth and families department, and is the state's

designated child welfare agency.

T. "PSD custody" means custody of children as a result of an action filed pursuant to the New Mexico Children's Code, 32A-4-1 NMSA 1978 or 32A-3B-1 NMSA 1978.

U. "Relative" means a person related to another person by birth, adoption or marriage within the fifth degree of consanguinity

V. "Safe" is the term used to describe CYFD's assessment based upon available information that a child's immediate circumstance or environment is free from persons and situations that have been identified as possible causes of harm to the child.

W. "Sex or human trafficking" consists of a child or youth who may have experienced being recruited, solicited, enticed, harbored, exploited or transported by another person whose intent is to exploit or use force, fraud, manipulation or coercion to subject the child or youth into labor, services or sexual activity.

X. "Sibling" means a brother or sister having one or both parents in common by birth or adoption.

Y. "Treatment foster care home" is a foster home licensed by a child placement agency to provide intensive therapeutic support, intervention and treatment for a child who would otherwise require a more restrictive placement.

Z. "Trial home visit" is the period of time, not to exceed six months, in which a child with a plan of reunification resides with the parent or guardian while services are provided to the child and family to address risk factors and ensure safety of the child.

AA. "Tribally licensed home" means a foster family homes licensed or approved by an Indian tribe or pueblo.

[8.10.8.7 NMAC - Rp, 8.10.8.7 NMAC, 09/29/15]

8.10.8.8 PURPOSE OF PERMANENCY PLANNING SERVICES:

A. Purpose: The purpose of permanency planning services is to systematically carry out, within a time-limited period, a set of goal-directed activities designed to help children live in families that offer the continuity of relationships with nurturing parents or guardians and the opportunity to establish healthy and positive lifetime relationships.

B. PSD provides permanency planning services to children or youth who come into the custody of PSD:

(1) through an abuse or neglect petition, voluntary placement outside of the home, or a family in need of court ordered services (FINCOS) case;

(2) as an undocumented immigrant child or youth through an abuse or neglect petition;

(3) as an unaccompanied alien child or youth as provided for and defined by the department of health and human services, administration for children and families, office of refugee resettlement, or division of unaccompanied children services;

(4) as an infant left at a hospital as outlined in the Safe Haven for Infants Act, 24-22-1 NMSA 1978; and

(5) as children returned to the custody of the parent, guardian or custodian subject to any condition or limitations as the court may prescribe including protective supervision of the child by PSD.

[8.10.8.8 NMAC - Rp, 8.10.8.8 NMAC, 09/29/15]

8.10.8.9 SAFETY ASSESSMENT IN PERMANENCY PLANNING:

A. The overriding concern throughout the life of a permanency planning case shall be the safety of the child. PSD shall be responsible for the continued assessment of the child's safety until case closure and shall determine:

(1) whether or not the responsibilities for care and protection of the child have been met by the parent, guardian or custodian; and

(2) if the child can safely return home to the parent, guardian or custodian.

B. PSD shall be responsible for assessing the child's safety during visitation with the parent, guardian, custodian or other family members, including the child's current living situation.

[8.10.8.9 NMAC - N, 09/29/15]

8.10.8.10 OUT OF HOME PLACEMENT: When a child cannot safely remain in his or her home, PSD shall pursue legal custody of the child. When the court has determined that it is contrary to the welfare of the child to remain in his or her home, PSD is awarded legal custody and placed with a licensed foster care provider to ensure the child's safety and well-being. The placement of a child into foster care shall not be delayed or denied on the basis of the race, color, sexual orientation, gender identity or national origin of the foster parent, or the child involved.

A. Entry into foster care: The child is considered to have entered foster care on the earlier of:

(1) the date of the first judicial finding that the child has been subjected to child abuse or neglect; or

(2) the date that is 60 days after the date on which the child is removed from the home.

B. Relative and relative notification:

(1) PSD shall give preference to relatives when making placement decisions. PSD considers fictive kin for placement if appropriate for best interest placement consideration.

(2) Within 30 days of the child's removal, PSD shall exercise due diligence to identify and notify the following relatives: all adult grandparents, all parents with legal custody of a sibling of the child, and other adult relatives of a child.

(3) When the court adopts a permanency plan other than reunification, and the child is not placed with a relative, PSD shall continue to make reasonable efforts to identify and locate appropriate and willing relatives to become licensed foster care providers.

C. Placement types: When the court places a child in the legal custody of PSD, PSD shall be responsible for placing that child with a licensed foster care provider, which may include, but is not limited to:

(1) relative and non-relative foster care;

(2) treatment foster care;

(3) a licensed facility such as residential treatment center, group home, or emergency shelter; or;

(4) a licensed community home.

D. Indian child placement: PSD shall make active efforts to place an Indian child in accordance with the placement preferences of the Indian Child Welfare Act (ICWA.), which may include placement in tribally licensed homes.

E. Least restrictive environment and proximity of placement:

(1) Children are placed in the least restrictive setting consistent with the assessment of their individual needs.

(2) PSD shall

make efforts to place children in close proximity to their home of origin; PSD shall document any reason as to why a child cannot be safely placed in close proximity to their home of origin.

F. Educational continuity: At the initial placement and any placement change thereafter, PSD shall develop plan for transportation for the child to remain in the same education setting in which the child was enrolled at the time of placement, if reasonable in the child's best interest.

G. Level of care assessment: PSD shall determine level of care within 30 days of entry into custody and every six months thereafter at a minimum. In addition, a determination will be made regarding the appropriateness of applying for social security insurance (SSI) or the developmentally disabled (DD) waiver.

H. Change of placement:

(1) When a child's placement is changed, including a return to the child's home, PSD shall provide written notice to the child's guardian ad litem or attorney, all parties, the child's CASA, the child's foster parents and the court. This notice is required ten days prior to the placement change, unless an emergency situation requires moving the child prior to the notice. When prior notice is not possible, written notice must be provided to the GAL or attorney, all parties, the CASA, the foster parents, and the court within three days after the placement change has occurred.

(2) Written notice is not required for removal of a child from respite. In respite situations, PSD shall provide verbal notification of the removal to the child's guardian ad litem or attorney.

(3) When a child, through his or her GAL or attorney, files a motion and requests a court hearing to contest the placement change, PSD shall not changes the child's placement pending the results of the court hearing, unless an emergency requires changing the child's placement prior to the hearing.

I. Sibling continuity:

(1) PSD shall make reasonable efforts to place siblings together when possible.

(2) PSD shall document reasons for not placing siblings together, such as when there are safety concerns or placement together is not a viable option.

(3) PSD shall facilitate visitation, as appropriate, between siblings not placed together or siblings who are not placed in PSD custody, including any adult siblings.

[8.10.8.10 NMAC - N, 09/29/15]

8.10.8.11 VOLUNTARY PLACEMENTS:

A. No parent may relinquish parental rights to PSD without PSD's consent.

B. When it has been determined to be in the best interest of the child parent, guardian or custodian, PSD may accept legal custody of a child placed voluntarily through a written agreement.

C. No child shall remain in voluntary placement for longer than one hundred eighty consecutive days or for more than one hundred eighty days in any calendar year; provided that a child may remain in voluntary placement up to an additional one hundred eighty consecutive days upon order of the court after the filing of a petition by PSD for extension of voluntary placement, a hearing and a finding that additional voluntary placement is in the best interests of the child.

D. In no event shall a child remain in voluntary placement for a period in excess of three hundred sixty-five days in any two-year period.

E. The PSD director or designee approves all voluntary placement agreements before accepting a voluntary placement.

F If the parent, guardian, or custodian requests PSD to return the child prior to the termination of the voluntary placement agreement, the child is returned within 72 hours of the request unless an abuse or neglect petition is filed concerning that child, and the court enters an order finding abuse or neglect, prior to the expiration of the 72 hours.

G. PSD develops a case plan with all families entering into a voluntary placement agreement.

[8.10.8.11 NMAC - N, 09/29/15]

8.10.8.12 THE PERMANENCY PLAN: The permanency plan reflects the permanency goal within the child's case plan to be achieved by PSD's intervention with the family. Permanency goals include:

A. Reunification: The goal of reunification is to safely reunify the child to the home of the parent or legal guardian. Reunification is the preferred goal in all cases unless the court finds that aggravated circumstances exist.

B. Adoption: The goal of adoption is to judicially terminate the rights, privileges and duties as between the child and the biological parent, and to judicially establish in another family such rights, privileges and duties as between a child and heir, and the adoptive parent.

C. Permanent guardianship: The goal of permanent guardianship is to establish a court-sanctioned arrangement which vests in a guardian all rights and responsibilities of a parent without terminating the rights of the parent as set forth in the Children's Code, Section 32A-4-32 NMSA 1978.

D. Placement with a fit and willing relative: The goal of placement with a fit and willing relative is to establish a court sanctioned relationship between the child and the child's relative in order to maintain family relationships to the extent possible, consistent with the best interests of the child.

E. Planned permanent living arrangement: The goal of a planned permanent living arrangement is to establish a court sanctioned arrangement to provide physical and emotional permanency for the child when the court determines that this is the most appropriate permanency plan for the child after considering all other permanency plans. Planned permanent living arrangement may only be used for youth over the age of 16.

[8.10.8.12 NMAC - N, 09/29/15]

8.10.8.13 CASE PLANNING:

A. As part of the initial case planning process, PSD shall hold an initial assessment planning conference prior to the ten day custody hearing. An initial assessment plan shall be developed at the assessment planning conference. The initial assessment plan is ordered at the custody hearing and remains in effect until a case plan is ordered at the dispositional hearing.

B. PSD shall develop a case plan to address safety threats to the child and include plan-directed activities for both the child and parent, guardian or custodian to achieve permanency without the need for the PSD intervention.

C. At a minimum, the case plan shall be re-assessed prior to any court hearing.

D. For children age 14 and older, the case plan shall be developed in consultation with the child and, at the option of the child, with up to two members of the case planning team who are chosen by the child and who are not a foster parent of, of caseworker for, the child. PSD may reject an individual selected by a child to be a member of the case planning team at any time if PSD has good cause to believe the individual

would not act in the best interest of the child. An individual shall be selected by the child to be a member of the child's case planning team, and may be designated to be the child's advisor and, as necessary, advocate with respect to the application of the reasonable and prudent parent standard to the child.

E. As part of the case plan, PSD shall provide the New Mexico foster child and youth bill of rights and the New Mexico foster youth document of responsibilities to youth age 14 or older.

(1) PSD shall provide a document that describes the rights of the child with respect to education, health, visitation, and court participation, the right to be provided with the documents and the right to stay safe and avoid exploitation.

(2) PSD shall obtain a signed acknowledgement that the child has received a copy of those documents and understands those rights and responsibilities

F. **Other plans within the case plan:** As part of the case planning process the following plans shall be incorporated into the case plan as appropriate:

(1) Permanency plan: The permanency plan reflects the permanency goals to be achieved. Every child's case plan shall have a permanency plan, which may change throughout the life of the case.

(2) Concurrent plan: A concurrent plan means a second permanency plan of adoption or guardianship in addition to the primary permanency plan of reunification.

(3) Transition home plan: A transition home plan shall be submitted to the court prior to or at the initial permanency hearing when the child's plan remains reunification. The plan shall be completed within 90 days of the initial permanency hearing. The plan results in the child being placed with his or her parent, guardian or custodian on a trial home visit.

(a) As part of the transition home plan, PSD shall set up a trial home visit in which the child resides with his or her parent, guardian or custodian until it has been determined no safety threats exist to the child and the case can be dismissed. If the trial home visit is unsuccessful, then the child shall be removed from the home of the parent, guardian or custodian and placed in the same or another out of home placement.

(b) A trial home visit normally does not exceed six months in duration.

(c) If a trial home visit exceeds six months in duration, or exceeds a longer time period deemed appropriate by the court, and the child is subsequently returned to foster care, the placement is considered a new placement and procedures must be followed to newly establish title IV-E eligibility.

(4) Life skills plan: PSD shall develop a life skills plan, using the life skills assessment, with youth age 14 or older who are in the custody of PSD. The life skills plan shall identify the activities, tasks, and services needed for the youth to develop the life skills necessary to safely transition into independent living as an adult regardless of the child's permanency plan.

(5) Transition plan: PSD shall begin developing a transition plan with the child prior to the child's 17th birthday to identify a child's needs, strengths and goals in the areas of safety, housing, education, employment or income, physical health and mental health, local opportunities for mentors and continuing support services. The plan shall identify activities, responsibilities and timeframes to address specified goals. PSD shall present the transition plan to the court at the first hearing scheduled after the child's seventeenth birthday. The court shall order the transition plan for the child. The transition plan approved by the court shall be reviewed at every subsequent review and permanency hearing.
[8.10.8.13 NMAC - N, 09/29/15]

8.10.8.14 ADJUDICATION AND DISPOSITION:

A. PSD shall schedule a mandatory pre-adjudicatory meeting prior to the adjudicatory hearing.

B. The adjudicatory hearing shall be held within 60 days after the date of service on the respondent.

C. Prior to the dispositional hearing, PSD shall prepare a pre-dispositional study and report.

D. The dispositional hearing may occur simultaneously with the adjudicatory hearing, but no later than 30 days after the conclusion of the adjudicatory hearing.

E. Foster parents, pre-adoptive parents or relatives providing care to the child shall be given notice and an opportunity to be heard at the dispositional hearing.
[8.10.8.14 NMAC - N, 09/29/15]

8.10.8.15 INITIAL JUDICIAL REVIEW, FIRST PERMANENCY HEARING AND SUBSEQUENT HEARINGS:

A. The initial judicial review shall be held within 60 days of the dispositional hearing. PSD shall inform the court of the progress made toward the permanency plan.

B. The initial permanency hearing shall be commenced within six months of the initial judicial review of a child's dispositional order or within 12 months of a child entering foster care, whichever occurs first.

C. Prior to the initial permanency hearing, PSD shall attend a mandatory meeting with all other parties to mediate issues attendant to the permanency hearing and to develop a case pan that services in the child's best interest.

D. At the initial permanency hearing and subsequent hearings thereafter, PSD shall document the following:

(1) the efforts made to return the child home;

(2) the steps PSD has taken to ensure the child's foster care provider is following the reasonable and prudent parent standard;

(3) the steps PSD has taken to ensure the child has regular, ongoing opportunities to engage in age and developmentally appropriate activities.

E. PSD evaluates the status of each child within six months of the conclusion of the permanency hearing or, if a motion has been filed for termination of parental rights or permanent guardianship, within six months of the decision on that motion, and re-evaluates the status every six months thereafter so long as the child remains in custody. The evaluation includes a determination of the safety of the child, the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress that has been made toward alleviating or mitigating the causes necessitating placement in foster care. The evaluation also projects a likely date by which the child may be returned to and safely maintained in the home or placed for adoption or legal guardianship.
[8.10.8.15 NMAC - N, 09/29/15]

8.10.8.16 TERMINATION OF CUSTODY: PSD's custody of a child shall terminate under the following circumstances:

A. the court dismisses or terminates PSD's custody of a child;

B. a voluntary placement agreement expires;

C. court ordered custody

of the child expires;

D. the child reaches the age of 18; or

E. a child in PSD's custody marries or joins the armed forces.
[8.10.8.16 NMAC - Rp, 8.10.8.26 NMAC, 09/29/15]

8.10.8.17 MEDICAL AND BEHAVIORAL HEALTH:

A. Within the first 30 days of PSD custody, the child shall have a complete physical examination. The child shall receive an annual well-child check and dental and eye exam thereafter.

B. While a child is in the custody of PSD and until parental rights have been terminated, the child's parent, guardian or custodian shall continue to be responsible for the child's medical needs. If support by the parent, guardian or custodian is not available, PSD shall seek to obtain other medical coverage or, if all other possibilities are exhausted, to qualify the child for Medicaid through supplemental security income (SSI).

C. PSD shall obtain, if available, and keep current the child's immunization records. In any case, where the parent, guardian, or custodian objects to immunizing the child, PSD shall inform the parent, guardian, or legal custodian that he or she may obtain a waiver from the department of health objecting to the immunizations.

D. PSD shall arrange for behavioral health services for children, parents, guardians or custodians to address identified needs and to move the case planning process along in order for the child to achieve permanency.
[8.10.8.17 NMAC - N, 09/29/15]

8.10.8.18 EDUCATION:

A. PSD shall develop a plan for transportation with the foster care provider and child, if age appropriate, in order for the child to remain in the same education setting in which the child was enrolled at the time of placement, if reasonable and in the child's best interest.

B. PSD shall work with the child's school to identify the child's educational needs and the need for an individualized education plan (IEP) and if appropriate, assist in the development of the IEP. For children with an IEP, the PSD worker shall assist the child and the child's school in implementing the IEP.

C. For children in eighth grade and older, PSD shall request and review the child's next step plan and actively participate in updating the plan each year with the child to prepare post-secondary educational goals.

D. An educational decision maker shall be appointed for every child in PSD custody. The education decision maker shall be named prior to the custody hearing and shall be re-evaluated at every hearing thereafter.
[8.10.8.18 NMAC - N, 09/29/15]

8.10.8.19 VISITATION:

A. Family visits: PSD shall arrange for visitation between the child and his or her family or fictive kin as appropriate.

B. Sibling visits: PSD shall arrange for and facilitate visitation, as appropriate, between children in PSD custody and their siblings who are either in PSD custody, but not in same out of home placement, or siblings who are not in PSD custody including adult siblings.

C. Worker-child visits: PSD shall visit each child at least monthly in the child's placement to assess the placement for appropriateness in meeting the child's safety, emotional and well-being needs.

D. Worker-parent visits: PSD shall arrange for visits at least monthly with the parent, guardian or custodian to share information about the child and discuss case plan progress.
[8.10.8.19 NMAC - Rp, 8.10.8.22 NMAC, 09/29/15]

8.10.8.20 OUT-OF-STATE PLACEMENTS OF FOSTER CHILDREN: PSD shall visit each child in an out-of-state placement in that placement at least every six months. PSD, in accordance with the Interstate Compact for the Placement of Children (ICPC), shall request other receiving state child welfare agencies to visit the child in his or her placement monthly and provide PSD with reports on those visits.
[8.10.8.20 NMAC - Rp, 8.10.8.14 NMAC, 09/29/15]

8.10.8.21 INTERSTATE COMPACT FOR THE PLACEMENT OF CHILDREN (ICPC):

A. PSD may place children in custody in licensed out-of-state placements, and may accept children in the custody of another state for placement in New Mexico in accordance with the Interstate Compact for the Placement of Children (ICPC).

B. CYFD has no authority to license foster home in other states.
[8.10.8.21 NMAC - Rp, 8.10.8.27 NMAC, 09/29/15]

8.10.8.22 SPECIAL IMMIGRANT JUVENILE STATUS (SIJS): If a child is an undocumented foreign national PSD shall apply to the department of homeland security's (DHS) citizen and immigration services (USCIS) to obtain "special immigrant juvenile status" for the child.
[8.10.8.22 NMAC - N, 09/29/15]

8.10.8.23 CONSULAR NOTIFICATION: When PSD is given custody of a foreign national child, that is, a child who is not a citizen of the United States, PSD shall notify that child's foreign national consulate in writing within five business days.
[8.10.8.23 NMAC - N, 09/29/15]

8.10.8.24 PREVENTING, IDENTIFYING AND REPORTING SEX AND HUMAN TRAFFICKING AND REPORTING RUNAWAYS:

A. PSD shall identify, document, and determine appropriate services for children or youth who have disclosed or who may be at risk of being the victim of human trafficking.

B. PSD shall immediately, but not later than 24 hours, notify law enforcement of children or youth who PSD has identified as victims of sex or human trafficking.

C. PSD shall make reasonable efforts to locate children or youth missing from foster care, including determining factors that led to the child or youth being absent from foster care and assessing the child or youth's experience while absent from foster care, including whether the child or youth is a victim of sex or human trafficking.

D. PSD shall report immediately, but no later than 24 hours, after receiving information on missing or abducted children or youth to law enforcement authorities for entry into national crime information center (NCIC) database of the federal bureau of investigation.

E. PSD shall report immediately, but no later than 24 hours, after receiving information on missing or abducted children or youth to the national center for missing and exploited children.
[8.10.8.24 NMAC - N, 09/29/15]

8.10.8.25 INCIDENTS INVOLVING CHILDREN IN CUSTODY:

A. Incidents in foster care may refer to a broad spectrum of events which may include, but are not limited to, reports of:

(1) alleged

policy or procedures violations by foster parents, including foster parent failure to comply with case plan or safety plan requirements;

(2) alleged violations of the New Mexico foster child and youth bill of rights or the New Mexico foster youth document of responsibilities;

(3) serious illness or accidental injury of foster child;

(4) foster parent reporting concerns related to parent-child or sibling visitation; or

(5) foster child running away.

B. Incidents in foster care shall not include reports of alleged abuse or neglect. Reports of alleged abuse or neglect are called in to statewide central intake (SCI) and if warranted, assigned for PSD investigation.

[8.10.8.25 NMAC - N, 09/29/15]

8.10.8.26 TITLE IV-E AND MEDICAID ELIGIBILITY: PSD shall determine funding eligibility for each child in PSD custody.

[8.10.8.26 NMAC - N, 09/29/15]

8.10.8.27 MAINTENANCE PAYMENTS AND INCIDENTALS

A. Foster care providers are reimbursed for the care provided to children at rates established by the state legislature.

B. To be honored, request from foster care providers for reimbursements for pre-approved purchases must be submitted within 45 days of the expenditure.

C. PSD is not liable and will not reimburse any person for any loss or property damage, real or personal, in excess of $25,000, that is shown to be caused by a child in PSD custody.

[8.10.8.27 NMAC - N, 09/29/15]

8.10.8.28 FINANCIAL RESPONSIBILITY: Until parental rights have been terminated, the child's parents continue to be financially responsible for the child. PSD establishes a children's maintenance account for children in PSD custody who receive monetary benefits. Resources received on behalf of the child are used to reimburse PSD for the child's care and to meet the needs of the child.

[8.10.8.28 NMAC - Rp, 8.10.8.15 NMAC, 9/29/15]

8.10.8.29 COURT APPOINTED SPECIAL ADVOCATE (CASA) AND CITIZEN REVIEW BOARD (CRB):

A. If the court has appointed a CASA, PSD shall involve and inform the CASA as required by the Children's Code.

B. PSD refers each child in custody to the citizen review board as required by the New Mexico Children's Code. The citizen review board provides the foster parent or relative providing care for the child with timely notice of and an opportunity to be heard before the citizen review board. The notice and opportunity to be heard do not include the right to standing as a party in the case.

[8.10.8.29 NMAC - Rp, 8.10.8.25 NMAC, 09/29/15]

8.10.8.30 CHILD PROTECTIVE SERVICES CHILD CARE

A. PSD provides child protective services childcare as one part of a case for children and families receiving services to address child maltreatment safety and risk factors.

B. The purpose of protective services childcare are:

(1) to enable parents, guardian or custodians to participate in activities which are part of the comprehensive treatment plan;

(2) to enable foster parents to maintain employment, obtain job training and attend educational programs while children are in placement in the home; and

(3) to provide childcare as crisis intervention for those families who lack other resources, are at risk of child maltreatment, and unable to provide adequate care for their child.

C. PSD provides childcare:

(1) without regard to income eligibility;

(2) depending on the assessment of need for the child and family or foster family; and

(3) as appropriate and to maintain stability of a placement.

D. PSD arranges for childcare by providers who meet the requirements established by and who are licensed or certified by the CYFD childcare services bureau.

E. The child's worker determines an appropriate childcare provider in cooperation with the child's family or foster family.

F. PSD follows the service standards and payment rates for childcare that are established by the child care services bureau within CYFD's early childhood services division.

G. PSD arranges child protective services childcare from any of the following approved provider types:

(1) licensed family child care;

(2) certified family child care; and

(3) licensed childcare center.

[8.10.8.30 NMAC - N, 09/29/15]

8.10.8.31 DOCUMENTATION AND CONFIDENTIALITY:

A. Documentation: PSD shall maintain the case record, which consists of both the electronic record maintained in FACTS and the paper case record. The case record is a working tool and shall contain all documents that are necessary for the appropriate provision of services.

B. Confidentiality: All PSD staff and CYFD contractors shall maintain confidentiality of records and information in accordance with the laws and regulations that apply to specific services.

(1) Abuse and neglect records: Abuse and neglect records are confidential pursuant to the New Mexico Children's Code 32A-4-33(A) NMSA 1978. The name and information regarding the reporting party shall not be disclosed absent the consent of the reporting party or a court order.

(2) Foster care and adoption records: Under CYFD's general rulemaking authority Section 9-2A-7 NMSA 1978, the confidentiality provisions of the Children's Code, Sections 32A-3B-22 and 32A-4-33 NMSA 1978, the specific authority related to certification of foster homes, Section 40-7-4 (D) and the Adoption Act, Sections 32A-5-6 and 32A-5-8 NMSA 1978, all client case records and client identifying information including foster and adoptive families, and applicant files are confidential and may not be publicly disclosed. PSD may release such files only upon a valid court order provided that confidential criminal and abuse and neglect information may not be released, unless a court order specifically orders such a release.

(3) Records related to an adoption proceeding: Records related to an adoption proceeding are confidential pursuant to the Children's Code, Section 32A-5-8 NMSA 1978. Post decree adoption records: Guidance on obtaining access of post decree adoption records by an adult adoptee, biological parent of an adult adoptee, sibling of an adoptee, or adoptive parent of a minor

adoptee is outlined in the Adoption Act Regulations, Subsection C of 8.26.3.41 NMAC.

(4) Social security administration electronic records: Any information obtained through the social security administration (SSA) data system, ISD2, either directly or from another individual with access to the ISD2, is confidential. Improper access, use or disclosure of ISD information is a violation of the Privacy Act of 1974 (5 U.S.C. Section 552a, Public Law No 93-579), and could result in civil and criminal sanctions pursuant to applicable federal statutes. When a PSD becomes aware of a loss or suspected loss of any file containing ISD information (whether a hard copy file, or on a laptop, removable drive, etc.), PSD shall notify CYFD office of the general counsel (OGC) within one hour of the discovery of the loss.
[8.10.8.31 NMAC - Rp, 8.10.8.28 NMAC, 09/29/15]

HISTORY OF 8.10.8 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:
SSD Rule #411.0000, Substitute Care, filed 11/10/81;
SSD 5.0.0, Substitute Care for Children - Definition and Goal Statement, filed 8/22/86;
SSD 5.1.0, Substitute Care for Children - General Provision, filed 8/22/86;
SSD 5.1.0, Substitute Care for Children - General Provision, filed 1/29/87;
SSD 5.1.0, Substitute Care for Children - General Provision, filed 6/18/87;
SSD 5.1.0, Substitute Care for Children - General Provision, filed 3/28/89;
SSD Rule #410.5400, Substitute Care for Children - General Guidelines, filed 9/17/81;
SSD 5.2.0, Substitute Care for Children - General Guidelines, filed 8/22/86;
SSD 5.2.0, Substitute Care for Children - General Guidelines, filed 1/29/87;
SSD 5.2.0, Substitute Care for Children - General Guidelines, filed 6/18/87;
SSD 5.2.0, Substitute Care for Children - General Guidelines, filed 11/18/87;
SSD 5.2.0, Substitute Care for Children - General Guidelines, filed 1/13/88;
SSD 5.2.0, Substitute Care for Children - General Guidelines, filed 3/30/89;
SSD 5.2.0, Substitute Care for Children - General Guidelines, filed 7/14/89;
SSD 5.2.0, Substitute Care for Children - General Guidelines, filed 9/18/90;
SSD 5.3.0, Substitute Care for Children - Department Responsibilities, filed 8/22/86;
SSD 5.3.0, Substitute Care for Children - Department Responsibilities, filed 1/29/87;
SSD 5.3.0, Substitute Care for Children - Department Responsibilities, filed 11/18/87;
SSD 5.3.0, Substitute Care for Children - Department Responsibilities, filed 6/14/88;
SSD 5.3.0, Substitute Care for Children - Department Responsibilities, filed 8/22/88;
SSD 5.3.0, Substitute Care for Children - Department Responsibilities, filed 9/18/90;
SSD 5.3.0, Substitute Care for Children - Department Responsibilities, filed 3/15/91;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 8/22/86;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 1/29/87;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 6/18/87;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 11/18/87;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 8/22/88;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 3/28/89;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 3/20/90;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 9/18/90;
SSD 5.4.0, Substitute Care for Children - Licensing Standards for Foster Homes, filed 3/15/91;
SSD 3.3.0, Family Services - Department Responsibilities, filed 8/22/86;
SSD 3.3.0, Family Services - Department Responsibilities, filed 1/29/87;
SSD 3.3.0, Family Services - Department Responsibilities, filed 6/18/87;
SSD 3.3.0, Family Services - Department Responsibilities, filed 11/18/87;
SSD 3.3.0, Family Services - Department Responsibilities, filed 1/13/88

History of Repealed Material:
8.10.8 NMAC, Permanency Planning - Repealed, 2/14/01
8.10.8 NMAC, Permanency Planning - Repealed 7/15/04
8.10.8 NMAC, Permanency Planning - Repealed 11/15/05
8.10.8 NMAC, Permanency Planning - Repealed 9/29/15

CHILDREN, YOUTH AND FAMILIES DEPARTMENT

This is an amendment to 8.10.2 NMAC, Sections 7, 9, 13, 14, 15 and 16, effective 9/29/2015.

8.10.2.7 DEFINITIONS:
A. "Child abuse and neglect check" is a review of the PSD family automated client tracking system, also known as FACTS, or another state's central abuse or neglect registry to determine if there have been any previous referrals on the family to this state's or any other state's child protective services division.
B. "Children's Code" refers to the New Mexico [~~Children's Code, Section 32A-1-1, et. seq., NMSA 1978.~~] Children's Code, Section 32A-1-1 NMSA 1978.
C. "Child vulnerability" refers to the child's ability to protect him or herself from identified safety threats as well as the child's ability to care for himself or herself when the child's parent or guardian is not able to meet the child's basic needs.
D. "Collateral contact" refers to any person who may be able to provide information to the PSD worker during an investigation of alleged abuse or neglect, concerning the alleged abuse or neglect that would be helpful in assessing child vulnerabilities, safety threats and protective capacities.
E. "Custodian" as defined in the Children's Code, Section 32A-1-4(E) NMSA 1978 means an adult with whom the child lives who is not a parent or guardian of the child.
[~~E.~~] F. "CYFD" is the New Mexico children, youth and families department.
[~~F.~~] G. "FACTS" refers to the family automated client tracking system (FACTS), the official data management system for CYFD.
[~~G.~~] H. "Guardian" as defined in the Children's Code, Section 32A-1-4(I) NMSA 1978, means a person appointed as guardian by a court or Indian tribal authority or a person authorized to care for the child by a parental power of attorney as permitted by law.
[~~H.~~] I. "Impending danger" is when a child is living in a state of danger or position of continual danger due to a family circumstance or behavior. The threat caused by the circumstance or behavior is not presently occurring, but it can be anticipated to have severe effects on a child at any time.

[~~**I.** **"Indian child"** refers to an unmarried person who is:~~
~~**(1)** under the age of 18 years old;~~
~~**(2)** a member of an Indian tribe or is eligible for membership in an Indian tribe; and~~
~~**(3)** the biological child of a member of an Indian tribe.~~
~~**J.** **"Initiation"** of an investigation is the face-to face contact by a PSD worker with the alleged victim, or documented diligent efforts to establish face-to-face contact with the victim.~~]
J. **"Indian child"** means any unmarried person who is under age 18 and is either a member of an Indian tribe, or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.
K. **"Intake"** refers to the process by which intake workers receive, screen and prioritize reports of alleged child abuse or neglect.
L. **"Parent"** as defined in the Children's Code, Section 32A-1-4(P) NMSA 1978, includes a biological or adoptive parent if the biological or adoptive parent has a constitutionally protected liberty interest in the care and custody of the child.
M. **"Placement"** is an out of home residential arrangement for the care of children in PSD custody, which may include, but is not limited to family foster care, relative foster care and treatment foster care, or a facility such as residential treatment center, group home, or emergency shelter.
N. **"Present danger"** means immediate, significant and observable severe harm or threat of immediate and severe harm that is presently occurring to a child and requires an immediate protective services response.
O. **"Prioritization"** is the assignment of a time frame for PSD to initiate an investigation based upon the reported safety threats to the child, the age of the child and the protective capacities identified in the report (See herein at 8.10.2.13 NMAC).
P. **"Protective capacities"** are those assets possessed by the caregiver that help reduce, control or prevent present or impending danger of serious harm to a child.
Q. **"Protective services division (PSD)** refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.
R. **"PSD custody"** means custody of children as a result of an action occurring pursuant to the Children's Code, [~~Sections 32A-4-1 et seq. and 32A-3B-1 et seq NMSA 1978.~~] Sections 32A-4-1 and 32A-3B-1 NMSA 1978.
S. **"Report"** is a verbal or written presentation of information alleging child abuse or neglect that is received by an intake worker.
T. **"Reporter"** refers to any individual who has contacted statewide central intake (SCI) to make a report of alleged child abuse or neglect.
U. **"Safe Haven for Infants Act"** means an Act, Section 24-22-1 NMSA 1978, to promote the safety of infants and to immunize a parent from criminal prosecution for leaving an infant, 90 days of age or less, at a safe haven site. This Act is not intended to abridge the rights or obligations created by the federal Indian Child Welfare Act of 1978 or the rights of the parents.
V. **"Safe haven site"** as defined by Section 24-22-2 (F) NMSA 1978 means a hospital, law enforcement agency, or fire station that has staff onsite at the time an infant, 90 days of age or less, is left at such site.
[~~U.~~] W. **"Safety threats"** are threats of serious harm to a child that may create a present or impending danger.
[~~V.~~] X. **"Screened in report"** is a report that has met PSD's criteria for acceptance for investigation.
[~~W.~~] Y. **"Screened out report"** is a report that has not met PSD's criteria for acceptance for investigation.
[~~X.~~] Z. **"Statewide central intake (SCI)"** is the unit within PSD whose responsibilities may include, but are not limited to receiving and screening reports of alleged child abuse or neglect and prioritizing and assigning accepted reports to the appropriate county office for investigation.
[~~Y.~~] AA. **"Witness"** refers to a person who has a firsthand account of an event that is relevant to a PSD abuse and neglect investigation.
[8.10.2.7 NMAC - Rp, 8.10.2.7 NMAC, 03/31/10; A, 09/29/15]

8.10.2.9 ELIGIBILITY:
A. [~~Any child, birth up to age 18, shall be eligible for protective services intake without regard to income.~~] Any child, up to age 18, shall be eligible for protective services intake.
B. All individuals are required by the Children's Code, Section 32A-4-3(A) NMSA 1978 to report suspected child abuse or neglect to SCI or law enforcement if he or she knows, or has a reasonable suspicion that a child has been abused or neglected.
[8.10.2.9 NMAC - Rp, 8.10.2.9 NMAC, 03/31/10; A, 09/29/15]

8.10.2.13 PRIORITIZATION: Subject to the review and approval of the PSD intake supervisor, the intake workers shall prioritize accepted reports as follows:
A. Emergency report (E): A report alleging a serious and immediate safety threat involving a vulnerable child, including but not limited to an abandoned infant or child, any physical injury to an infant, a potentially life threatening situation, recent sexual abuse, a law enforcement request for immediate response, and recent serious trauma, such as a head injury, burns, or broken bones. [~~A report prioritized as an emergency requires that an investigation be initiated within three hours of the report's receipt by the assigned county office.~~] An emergency report requires that an investigation be initiated within three hours of the SCI supervisor's screening decision.
B. Priority one report (P1): A report alleging physical injury involving a vulnerable child who is in a safe environment at the time of the report, or a report alleging a serious impending safety threat involving a vulnerable child but where the alleged perpetrator will not have access to the child for the next 24 hours. [~~A P1 report requires that an investigation be initiated within 24 hours of the report's receipt by the assigned county office.~~] A priority one report requires that an investigation be initiated within 24 hours of the SCI supervisor's screening decision.
C. Priority two report (P2): A report alleging an impending safety threat involving a vulnerable child with no immediate concern for the child's safety. This may include, but is not limited to, alleged physical abuse with no indication of injury or alleged abuse or neglect where the alleged perpetrator no longer has access to the child or a protective parent or guardian has already intervened. [~~A P2 report requires that an investigation be initiated within five calendar days of the report's receipt by the assigned county office.~~] A priority two report requires that an investigation be initiated within five calendar days of the SCI supervisor's screening decision.
D. Custody of safe haven infant: When SCI receives a report that an infant has been left under the provision of the Safe Haven for Infants Act at a safe haven site, as defined above at 8.10.2.7 NMAC, the children, youth and families department through its protective services

division is deemed to have emergency custody of that infant. Law enforcement is not notified and a law enforcement investigation or 48 hour hold is not required.
[8.10.2.13 NMAC - Rp, 8.10.2.13 NMAC, 03/31/10; A, 09/29/15]

8.10.2.14 [~~PSD REPORTING REQUIREMENTS:~~] CROSS REPORTING AND NOTIFICATION:

A. ~~When it is the professional opinion of PSD staff that a reasonable suspicion of child abuse or neglect exists, PSD shall make a report to the appropriate local law enforcement agency.~~] PSD intake workers shall cross report all reports to the appropriate law enforcement agency pursuant to the New Mexico Children's Code, Section 32A-4-3(B) NMSA 1978.

[~~**B.** PSD intake workers shall refer screened out reports to other agencies as resources exist or as required by law.~~]

[~~C.~~] B. When the alleged perpetrator of abuse or neglect is not a parent or guardian, [~~e.g.~~] for example a coach, schoolteacher, or neighbor, PSD workers shall receive the information from the reporting source and shall inform the reporter that it will refer the allegation to the appropriate local law enforcement agency.

[~~D.~~] C. When the report received involves an Indian child on the reservation or pueblo, PSD intake workers shall immediately transmit the information to the appropriate tribal authority, such as tribal law enforcement or tribal social services.

D. When SCI receives a report alleging abuse or neglect of a child residing in a facility, or a child not in custody residing outside of their home, the intake worker shall screen out the report and email the report to the CYFD licensing and certification authority and to the CYFD office of inspector general.
[8.10.2.14 NMAC - Rp, 8.10.2.14 NMAC, 03/31/10; A, 09/29/15]

8.10.2.15 HIGH PROFILE CASE, SERIOUS INJURY AND CHILD FATALITIES: SCI shall initiate an internal notification protocol within CYFD when a SCI supervisor has determined a report involves a serious injury, child fatality or may be a high profile case.
[8.10.2.15 NMAC - Rp, 8.10.2.15 NMAC, 03/31/10; A, 02/29/12; 8.10.2.15 NMAC - N, 09/29/2015]

[~~8.10.2.15~~] 8.10.2.16 DOCUMENTATION REQUIREMENTS FOR INTAKE:

A. PSD intake workers shall make a record of all reports received regarding alleged child abuse or neglect.

B. PSD shall maintain records of all reports as follows:

(1) Screened out reports shall be maintained for one year after date of last activity concerning client, as required by Subsection D of 1.18.690.31 NMAC.

(2) Accepted reports shall be maintained as part of the investigation case record for 18 years after case closure, as required by Paragraph (2) of Subsection D of 1.18.690.30 NMAC.
[8.10.2.16 NMAC - Rn, 8.10.2.15 NMAC, 09/29/15]

CHILDREN, YOUTH AND FAMILIES DEPARTMENT

This is an amendment to 8.10.9 NMAC, Sections 6 through 19 and 21 through 23, effective 9/29/2015.

8.10.9.6 OBJECTIVE: To establish standards and practices for the provision of services to older youth aged [~~fifteen and a half (15.5)~~] 14 or older in protective services division [~~(PSD)~~] custody who are likely to age out of foster care at age 18, youth who have [~~emancipated~~] aged out from foster care at age 18, and youth who were adopted from foster care after the age of [~~sixteen (16)~~] 16; to promote the safety of the youth, promote positive youth development; and assist the youth in successfully transitioning into adult living.
[8.10.9.6 NMAC - Rp, 8.10.9.6 NMAC, 3/31/10; A, 9/29/15]

8.10.9.7 DEFINITIONS:
[~~**A.** **"Adelante"** is a non-governmental youth advocacy and advisory board composed of youth from around the state that represents current and former foster care youth. The board evaluates policies and practices of the child welfare system and advocates for system improvements. Adelante educates other youth, resource families, child welfare workers, and the general public on issues related to youth in foster care.~~

~~**B.** **"Case plan"** is an agreement developed between the youth, family (which may include but is not limited to biological family, foster family, or fictive kin), and other service providers outlining the tasks necessary to achieve the youth's identified goals.~~]

A. "Case plan" means a plan created jointly with clients for a child, youth, parent, guardian, custodian or respondent that identifies the appropriate services based on the needs identified to achieve the child's or youth's permanency plan and to promote the safety and well-being of each child or youth.

[~~C.~~] B. "Chafee Act" refers to the John H. Chafee Foster Care Independence Act of 1999, which allows states to provide services and funds to youth likely to age out of foster care, youth adopted after the age of [~~sixteen (16)~~] 16 from the foster care system, and youth who have [~~emancipated from~~] aged out of foster care at the age of 18.

[~~D.~~] C. "Discharge hearing" is a hearing required by the New Mexico Children's Code, Section 32A-4-25.3 NMSA 1978, [~~that~~] which takes place at the last judicial review or permanency hearing held prior to the youth's [~~eighteenth (18th)~~] 18th birthday. At the discharge hearing the court reviews the youth's transition plan and determines whether or not PSD has made reasonable efforts to meet the requirements outlined in the New Mexico Children's Code, Section 32A-4-25.3(B) NMSA 1978. (See herein at 8.10.9.17 NMAC)

[~~E.~~] D. "Education and training voucher (ETV) program" is a Chafee Act program that provides financial assistance to eligible youth who are enrolled in an accredited post-secondary educational setting.

[~~F.~~] E. "FACTS" is the family automated client tracking system, PSD's [~~management~~] information management system.

[~~G.~~] F. "Fictive kin" is a person not related by birth or marriage who has an emotionally significant relationship with the child.

G. "Foster care provider" refers to a person or entity licensed by CYFD, licensed by another state's child welfare agency, or a licensed child placement agency to provide foster care services including respite, non-relative, relative, or treatment foster care.

H. "Leaders uniting voices youth advocates of New Mexico" or "LUVYANM" is a non-governmental youth advocacy and advisory board composed of youth from around the state that represent current and former foster care youth. The board evaluates policies and practices of the child welfare system and advocates for system improvements. LUVYANM educates other youth, resource families, child welfare workers

and the general public on issues related to youth in foster care.

[~~H.~~] **I.** **"Life skills"** are the skills that a youth must develop to safely transition into adulthood, as identified in the independent living assessment discussed herein at 8.10.9.10 NMAC.

[~~I.~~] **J.** **"National youth transition database (NYTD)"** is a database, required by the Chafee Act. It tracks and reports on both services provided to and outcomes for older youth.

[~~**J.** **"Out-of-home provider"** refers to a foster care parent or other residential care provider.~~]

K. **"Permanency planning worker (PPW)"** has primary responsibility for youth in custody and works in collaboration with the youth transition specialist (YTS) (herein defined at Subsection T of 8.10.9.7 NMAC) to promote the [~~safety of~~] safety, permanency and well-being for the youth, promote positive youth development, and assist the youth in successfully transitioning into adult living.

L. **"Planned permanent living arrangement (PPLA)"** [~~is a permanency plan for a child who resides in an out-of-home placement and is established when the court determines that this is the most appropriate permanency plan for the child after ruling out reunification, adoption, permanent guardianship, and placement with a fit and willing relative.~~] is a permanency plan established by the court for a youth in PSD custody who is age 16 or older once reunification, adoption, permanency guardianship and placement with a fit and willing relative have been ruled out.

M. **"Positive youth development"** is a set of practices in working with youth to provide the necessary supports as they build their capacities and strengths to meet their personal and social needs. Youth are viewed as partners in working toward a successful transition to adulthood.

N. **"PSD"** refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

O. **"PSD custody"** means custody of children as a result of an action filed under the New Mexico Children's Code, [~~Sections 32A-4-1 or 32A-3B-1 et seq. NMSA 1978~~] Sections 32A-4-1 or 32A-3B-1 NMSA 1978.

P. **"Sex or human trafficking"** consists of a child or youth who may have experienced being recruited, solicited, enticed, harbored, exploited or transported by another person whose intent is to exploit or use force, fraud, manipulation or coercion to subject the child or youth into labor, services or sexual activity.

Q. **"Start-up funds"** are funds available through the Chafee Act to assist eligible youth in purchasing the household items [~~and/or~~] and services needed to establish a home or to support the youth's transition into adulthood. [~~Start-up funds are described in further detail herein at 8.10.9.19 NMAC.~~ ~~**"Transition support services"** refers to an array of services provided by or arranged by the YTS for the purpose of preparing and assisting youths in their transition to adulthood.~~]

R. [~~**"Youth in custody"** means youth age fifteen and a half (15.5) or older in the legal custody of PSD through an abuse/neglect petition or family in need of services petition filed under the New Mexico Children's Code, Sections 32A-4-1 or 32A-3B-1 et seq. NMSA 1978.~~] **"Transition plan"** refers to the plan developed with the youth prior to the youth's 17th birthday to identify a youth's needs, strengths and goals in the areas of safety, housing, education, employment or income, physical and mental health, local opportunities for mentors and continuing support services.

S. **"Youth"** for the purposes of 8.10.9 NMAC, means youth age 14 and older in the legal custody of PSD through and abuse and neglect petition or family in need of services petition filed under the New Mexico Children's Code, Sections 32A-4-1 or 32A-3B-1 NMSA 1978.

[~~S.~~] **T.** **"Youth services"** means any independent living or transition service arranged or provided by a YTS (in collaboration with permanency planning services) to a youth in custody, a youth who has [~~emancipated from~~] aged out of foster care at age 18, or a youth who was adopted after the age of [~~sixteen (16)~~] 16 in order to promote the safety of the youth, promote positive youth development, and assist the youth in successfully transitioning into adult living.

[~~T.~~] **U.** **"Youth transition specialist (YTS)"** [~~is a PSD worker who works in conjunction with the PPW with regard to all youth in custody age fifteen and a half (15.5) or older, including youth who are age eighteen (18) who remain under the jurisdiction of the court, and any youth with a permanency plan of PPLA. The YTS has primary responsibility for youth who have emancipated from foster care and are working with PSD on a voluntary basis.~~] is a PSD worker who works in conjunction with the PPW with regard to all youth in custody age 14 or older, including youth age 18 who remain under the jurisdiction of the court, and youth who were adopted at age 16 and older. The YTS has primary responsibility for youth who have aged out of foster care at age 18 and are working with PSD on a voluntary basis.

[8.10.9.7 NMAC - Rp, 8.10.9.7 NMAC, 3/31/10; A, 9/29/15]

8.10.9.8 PURPOSE OF YOUTH SERVICES: [~~Youth services shall be provided to assist youth in successfully transition into adult living; to promote the safety of youth; and to promote positive youth development. Youth services shall be provided to youth in custody, youth who have emancipated from foster care, and youth who were adopted after the age of sixteen (16) from foster care.~~]

A. Youth services shall:

(1) assist youth in successfully transitioning into adult living;

(2) promote self-sufficiency;

(3) promote the safety, permanency and well-being of youth;

(4) promote positive youth development; and

(5) promote relationships with mentors and other supportive adults.

B. Youth services shall be provided to youth in custody, youth who have aged out of foster at age 18, and youth who were adopted from foster care after the age of 16.

[8.10.9.8 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.9 ELIGIBILITY FOR YOUTH SERVICES:

A. Youth services shall be provided to all youth in the custody of PSD through an abuse or neglect petition, or a family in need of court ordered services petition, including youth in residential treatment or incarcerated youth, runaway youth and youth with a partial or complete developmental, emotional or physical disability.

B. [~~Eligibility requirements according to the specific service components involved. See 8.10.9.18-22 NMAC herein for eligibility requirements related to the specific service components of the youth services program.~~] Eligibility requirements according are specific to services components within the youth services program. See 8.10.9.18-21 NMAC herein for eligibility requirements related to the

specific service components.
[8.10.9.9 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.10 INDEPENDENT LIVING ASSESSMENT:
[**A.** The initial independent living assessment (IL assessment) shall be completed by all youth in PSD custody and his or her PPW within sixty (60) days:
(1) of a youth in PSD custody turning fifteen and a half (15.5) years of age;
(2) when a youth over the age of fifteen and a half (15.5) years enters PSD custody and remains in custody after the custody hearing; or
(3) of the court establishing of a PPLA plan for a youth under the age of fifteen and a half (15.5) years.
B. The IL assessment consists of three components:
(1) the Ansell-Casey life skills assessment;
(2) a current psychosocial history focused on the youth's strengths and goals; and
(3) a screening to determine whether a referral for adult protective services is warranted.
C. The PPW shall prepare a written summary of the IL assessment in FACTS. A copy the assessment and the summary are provided to the youth and his or her out-of-home provider.
D. The PPW may conduct a reassessment at any time. A reassessment shall be conducted prior to the youth's transition meeting if, at the time of the meeting, it will have been twelve (12) months or more since the previous assessment was completed. A youth may also request a reassessment at any time.]
A. All youth age 14 and older in PSD custody shall complete the initial independent living assessment (IL assessment) with his or her PPW.
B. The initial IL assessment consists of two components:
(1) the Casey life skills assessment; and
(2) a current psychosocial history focused on the youth's strengths and goals.
C. The PPW shall prepare a written summary of the IL assessment. A copy of the IL assessment and summary are provide to the youth and his or her foster care provider.
D. A re-assessment shall be conducted every 18 months until the youth is dismissed from custody or ages out of foster care. The PPW may conduct or a youth may request a re-assessment at any time.
E. PSD shall complete a screening to determine whether a referral for adult protective services shall be warranted for youth age 16 and older.
[8.10.9.10 NMAC - N, 3/31/10; A, 09/29/15]

8.10.9.11 LIFE SKILLS PLAN: The life skills plan shall be developed to assist the youth in successful transition to adulthood by establishing goals and addressing strengths and needs as a result of the IL assessment.
A. [The life skills plan is plan required by the New Mexico Children's Code, Section 32A-4-21 (B) (11) NMSA 1978, for each youth aged sixteen (16) or older in PSD custody that PSD shall present to the court prior to a dispositional hearing, regardless of the youth's permanency plan and for younger youth with a plan of PPLA. The PPW shall develop the plan with input from the youth, the YTS and the youth's out-of-home provider using the results of the IL assessment.] The life skills plan shall be included as part of the case plan for each youth aged 14 and older in PSD custody. PSD shall present the life skills plan to the court prior to the first hearing after the youth's 14th birthday and every subsequent hearing, regardless of the youth's permanency plan. The case plan shall be developed using the result of the IL assessment and in consultation with the youth, and at the option of the youth, with up to two members of the case planning team who are chosen by the youth and who are not a foster parent of, or a caseworker for the youth. PSD may reject an individual selected by the youth to be a member of the case planning team at any time PSD has good cause to believe that individual would not act in the best interest of the youth. An individual selected by the youth to be a member of the youth's case planning team may be designated to be the youth's advisor, and as necessary, the youth's advocate with respect to the application of the reasonable and prudent parent standard to the youth. The PPW shall also solicit input from the YTS, the youth attorney, and the youth's foster care provider.
B. The life skills plan shall identify the activities, tasks, and services needed for the youth to develop the life skills necessary to safely transition into independent living as an adult regardless of whether the [child is returned to the parents' home.] youth is reunified. The plan shall contain specific time frames and responsibilities for each activity included.
C. The plan shall be included in the youth's case plan and is reviewed by the court at every judicial review or permanency hearing.
[8.10.9.11 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.12 LIFE SKILLS DEVELOPMENT: [Life skills development shall be required for all youth in PSD custody regardless of permanency plan beginning no later than age sixteen (16). Life skills development is an individualized process of learning the knowledge and skills necessary to be successful in living as an adult. It may include, but is not limited to group learning, taking advantage of teachable moments, individual practice with out-of-home providers, and use of community resources.]
A. Life skills development shall be required for all youth in PSD custody regardless of permanency plan beginning no later than age 14. Life skills development is an individualized process of learning the knowledge and skills necessary to be successful in living as an adult. It may include, but is not limited to group learning, taking advantage of teachable moments, individual practice with out-of-home providers, and use of community resources.
B. The YTS shall assist each youth age 14 and older in obtaining a copy of his or her credit report at no cost to the youth. This process shall be completed on an annual basis until the youth is discharged from foster care.
[8.10.9.12 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.13 TRANSITION SUPPORT SERVICES: Transition support services shall be provided by or arranged by the YTS for the purpose of preparing and assisting youth in their transition to adulthood. Services begin at the preparation for the transition meeting and may continue until the youth turns [twenty-one (21)] 21 years of age. Youth in PSD custody shall be eligible for transition support services. Youth who have [emancipated from foster care] aged out of foster care at age 18 and youth [eighteen (18) to twenty-one (21)] 18 and 21 years of age who were adopted after the age of [sixteen (16)] 16 may request transition support services.
[8.10.9.13 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.14 YOUTH LEADERSHIP SKILLS: [PSD workers shall identify opportunities for youth to develop leadership skills including, but not limited to membership in Adelante, the statewide youth advisory board, participation in the annual independent living youth conference, training and public speaking. Youth in PSD custody are eligible for youth leadership skills. Youth who have emancipated from foster care and youth who were adopted after the age of sixteen (16) may request to participate in youth leadership skills development opportunities.] PSD shall identify opportunities for youth in PSD custody to develop leadership skills including, but not limited to membership in LUVYANM, participation in the annual independent living youth conference, training and public speaking. Youth who have aged out of foster care at age 18, and youth who were adopted after the age of 16 may request to participate in youth leadership skills development opportunities.
[8.10.9.14 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.15 [TRANSITION MEETING: Pursuant to the New Mexico Children's Code, Section 32A-4-25.2.A NMSA 1978, PSD shall conduct a transition meeting for each youth in custody prior to the youth's seventeenth (17th) birthday. The meeting includes the youth, the youth's YTS, the child's attorney and others of child's choosing, including biological family members. The purpose of the meeting is to develop the youth's transition plan. (See 8.10.9.16 NMAC below.)] **YOUTH TRANSITION MEETING (YTM):** Pursuant to the New Mexico Children's Code, Section 32A-4-25.2.A NMSA 1978, PSD shall conduct a transition meeting for each youth in custody prior to the youth's 17th birthday. The meeting shall include the youth, the YTS, the PPW and the youth attorney. The youth may choose to invite other participants, such as biological family members or foster care providers. The purpose of the meeting is to develop the youth's transition plan. (See 8.10.9.16 NMAC below.)
[8.10.9.15 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.16 TRANSITION PLAN:

A. Pursuant to the New Mexico Children's Code, Section 32A-4-25.2 A, B and C NMSA 1978, a written individualized transition plan shall be developed collaboratively [at the transition meeting by the youth, the YTS, the youth's youth attorney, and others in attendance at the meeting.] with the participants present at the YTM.

B. The transition plan shall identify a youth's needs, strengths and goals in the areas of safety, housing, education, employment or income, health and mental health, local opportunities for mentors and continuing support services. The plan shall identify activities, responsibilities and timeframes to address the goals specified in the transition plan.

C. Pursuant to the New Mexico Children's Code, Section 32A-4-25.2 B and C NMSA 1978, PSD shall present the transition plan to the court at the first hearing scheduled after the child's [seventeenth (17th)] 17th birthday. The court shall order the transition plan for the child. The transition plan approved by the court shall be reviewed at every subsequent review and permanency hearing.

D. The YTS shall review and update the youth's transition plan with the youth at least once, one month prior to the youth's 18th birthday.
[8.10.9.16 NMAC - Rp, 8.10.9.11 NMAC, 3/31/10; A, 9/29/15]

8.10.9.17 DISCHARGE HEARING:

A. Pursuant to the New Mexico Children's Code, Section 32A-4-25.3 NMSA 1978, at the last judicial review or permanency hearing held prior to the youth's [eighteenth (18th)] 18th birthday, the court shall conduct the youth's discharge hearing.

B. [At the discharge hearing the court shall review the youth's transition plan and determines whether or not the PSD has made reasonable efforts to:

(1) provide the youth with written information concerning the youth's family history, the whereabouts of any sibling, if appropriate, and education and health records;

(2) provide the youth with his or her social security card, certified birth certificate, state-issued identification card, death certificate of a parent and proof of citizenship or residence;

(3) assist the youth in obtaining medicaid, unless the youth is ineligible; and

(4) refer the youth for guardianship or limited guardianship if the youth is incapacitated.] At the discharge hearing the court shall review the youth's transition plan and determines whether or not the PSD has made reasonable efforts to:

(1) provide the youth with written information concerning the youth's family history, the whereabouts of any sibling, if appropriate, and education and health records;

(2) provide the youth with his or her health insurance information, medical, education and health records;

(3) provide the youth with his or her social security card, certified birth certificate, driver's license or state-issued identification card, death certificate of a parent and proof of citizenship or residence;

(4) assist the youth in obtaining medicaid, unless the youth is ineligible; and

(5) refer the youth for guardianship or limited guardianship if the youth is incapacitated.

C. If the court finds that PSD has not made reasonable efforts regarding all of the requirements in [Paragraphs (1) - (4)] Paragraphs (1) - (5) of Subsection B of 8.10.9.17 NMAC above, and that termination of jurisdiction would be harmful to the young adult, the court may continue to exercise its jurisdiction for up to one [(1)] year after the youth's [eighteenth (18th)] 18th birthday, provided the youth consents.
[8.10.9.17 NMAC - N, 3/31/10; A, 9/29/15]

8.10.9.18 INDEPENDENT LIVING PLACEMENT STATUS (ILPS): Independent living placement status allows an eligible youth to become his or her own vendor to receive [substitute care] monthly maintenance payments. The maintenance payment allows the youth to live as a boarder with a foster parent or to live independently with limited PSD supervision regarding safety and appropriate use of funds.

A. A youth age [eighteen (18)] 18 up to age [twenty-one (21)] 21 who has [emancipated from foster care] aged out of foster care at age 18 may be eligible for an independent living placement as determined by the YTS with supervisory approval.

B. With the approval of the [deputy director, a youth age seventeen (17)] regional manager and the youth services bureau chief, a youth age 17 in PSD custody may be eligible for ILPS, with the monthly maintenance payment provided with state general funds.

C. To assess whether ILPS is appropriate for a youth age [seventeen (17) the PPW shall review the IL assessment and all other relevant information and determines:] 17, the PPW

shall review the IL assessment and all other relevant information and determine whether:

(1) [~~that~~] the youth has the basic skills necessary to safely live independently; and

(2) [~~whether sufficient supports may be made available to the youth while living independently.~~] sufficient supports are available to the youth while living independently.

D. [~~The PPW shall prepare a memorandum for decision to the PSD deputy director about whether ILPS is appropriate for a youth age seventeen (17), discussing the IL assessment and describing the housing the youth will secure.~~] The PPW shall prepare a memorandum for decision to the regional manager and youth services bureau chief about whether ILPS is appropriate for a youth age 17, discussing the IL skills assessment and describing the housing the youth will secure.

E. Eligibility for ILPS is reassessed on a continuing basis and may be revoked at PSD's discretion.

F. Under no circumstance, may a youth in custody on runaway status simultaneously be on ILPS.

[8.10.9.18 NMAC - Rp, 8.10.9.13 NMAC, 3/31/10; A, 9/29/15]

8.10.9.19 START-UP FUNDS: Start-up funds shall be available for eligible youth to assist them in purchasing household items or services needed to establish a home or to further independence. [~~Lifetime eligibility shall be limited to $1500.~~] Expenses which are eligible for the use of start-up funds are determined according to the standards of the Chafee Act.

[8.10.9.19 NMAC - Rp, 8.10.9.14 NMAC, 3/31/10; A, 9/29/15]

8.10.9.21 [~~**CHAFEE MEDICAID:**~~ ~~Youth age eighteen (18) up to twenty-one (21) who were in foster care on their eighteenth (18th) birthday shall be eligible for medicaid according to the provisions of the Chafee Act. Before the youth's eighteenth (18th) birthday, or upon the youth's request for medicaid benefits, the youth shall complete and sign the application for Chafee medicaid. The youth shall complete a new application and submit it to the YTS each year thereafter.~~] **MEDICAID:** Youth age 18 up to 26 who were in foster care and enrolled in medicaid on their 18th birthday shall be eligible for medicaid according to the provisions of the Affordable Care Act. Before the youth's 18th birthday, or upon the youth's request for medicaid benefits, the youth shall complete and sign the application for medicaid. The youth shall complete a new application and submit it to the YTS each year thereafter.

[8.10.9.21 NMAC - Rp, 8.10.9.16 NMAC, 3/31/10; A, 9/29/15]

8.10.9.22 PREVENTING, IDENTIFYING AND REPORTING SEX AND HUMAN TRAFFICKING AND REPORTING RUNAWAYS:

A. PSD shall identify, document, and determine appropriate services for children or youth who have disclosed or who may be at risk of being the victim of human trafficking.

B. PSD shall immediately, but not later than 24 hours, notify law enforcement of children or youth who PSD has identified as victims of sex or human trafficking.

C. PSD shall make reasonable efforts to locate children or youth missing from foster care, including determining factors that led to the child or youth being absent from foster care and assessing the child or youth's experience while absent from foster care, including whether the child or youth is a victim of sex or human trafficking.

D. PSD shall report immediately, but no later than 24 hours, after receiving information on missing or abducted children or youth to law enforcement authorities for entry into national crime information center (NCIC) database of the federal bureau of investigation.

E. PSD shall report immediately, but no later than 24 hours, after receiving information on missing or abducted children or youth to the national center for missing and exploited children.

[8.10.9.22 NMAC - N, 9/29/15]

[~~8.10.9.22~~] 8.10.9.23 NATIONAL YOUTH IN TRANSITION DATATBASE (NYTD): NYTD is a database required by the federal Chafee Act which tracks and reports on services provided to and outcomes for older youth. To ensure that data is accurately maintained for purposes of meeting NYTD requirements, the PPW shall update medical and education information in FACTS. Both the PPW and YTS shall document all services provided to the youth. [~~The YTS shall work with the youth to complete the NYTD survey within forty-five (45) days of the youth's seventeenth (17th) birthday and at ages nineteen (19) and twenty-one (21).~~] The YTS shall work with the youth to complete the NYTD survey within 45 days of the youth's 17th birthday and at ages 19 and 21.

[8.10.9.23 NMAC - Rn & A, 8.10.9.22 NMAC, 9/29/15]

CHILDREN, YOUTH AND FAMILIES DEPARTMENT

This is an amendment to 8.15.2 NMAC, Section 17, effective September 29, 2015.

8.15.2.17 PAYMENT FOR SERVICES: The department pays child care providers on a monthly basis, according to standard practice for the child care industry. Payment is based upon the child's enrollment with the provider as reflected in the child care placement agreement, rather than daily attendance. As a result, most placements reflect a month of service provision and are paid on this basis. However, placements may be closed at any time during the month. The following describes circumstances when placements may be closed and payment discontinued at a time other than the end of the month:

A. When the eligibility period as indicated by the child care placement agreement expires during the month, including the end of a school semester; or when the provider requests that the client change providers or the provider discontinues services; payment will be made through the last day that care is provided.

B. Upon a change of provider the client and former provider have three days after the 5th day of nonattendance to notify the department. If this requirement for notification was met, the provider will be paid through the 14th day following the first date of nonattendance. If notification requirement is not met, the provider will be paid through the last date of attendance. The agreement with the new provider shall become effective when payment to the previous provider ceases. If the client notifies the department of the change in providers fewer than 14 days before the change will take place or after the change has taken place, the client is responsible for payment to the new provider beginning on the start date at the new provider and continuing up until the final date of payment to the former provider, as described above. Payment to the former provider will be made through the last day that care is provided if the child is withdrawn from the provider because the health, safety or welfare of the child is at

risk, as determined by a substantiated complaint against the child care facility.

C. The amount of the payment is based upon the average number of hours per week needed per child during the certification period. The number of hours of care needed is determined with the parent at the time of certification and is reflected in the provider agreement. Providers are paid according to the units of service needed which are reflected in the child care agreement covering the certification period.

D. The department pays for care based upon the following units of service:

Full time	Part time 1	Part time 2 (only for split custody or in cases where a child may have two providers)	Part time 3
Care provided for an average of 30 or more hours per week per month	Care provided for an average of 8-29 hours per week per month	Care provided for an average of 6-19 hours per week per month	Care provided for an average of 7 or less hours per week per month
Pay at 100% of full time rate	Pay at 75 % of full time rate	Pay at 50 % of full time rate	Pay at 25% of full time rate

E. Hours of care shall be rounded to the nearest whole number.

F. Child care placement agreements for out of school time care shall be opened and closed concurrent with the beginning and end of summer vacations, with the exception of year round school.

G. Monthly reimbursement rates:

Licensed child care centers			
Infant	Toddler	Pre-school	School-age
$720.64	$589.55	[~~$457.61~~] $490.61	[~~$406.27~~] $436.27
Licensed group homes (capacity: 7-12)			
Infant	Toddler	Pre-school	School-age
$586.07	$487.11	[~~$398.40~~] $427.13	[~~$393.67~~] $422.74
Licensed family homes (capacity: 6 or less)			
Infant	Toddler	Pre-school	School-age
$566.98	$463.50	[~~$383.94~~] $411.62	[~~$378.85~~] $406.83
Registered homes and in-home child care			
Infant	Toddler	Pre-school	School-age
$289.89	$274.56	$251.68	$251.68

H. The department pays a differential rate according to the license or registration status of the provider, national accreditation status of the provider if applicable, and Star level status of the provider if applicable.

I. Providers holding and maintaining CYFD approved national accreditation status will receive [~~an additional $250.00~~] the differential rate listed in Subsection J below, per child per month for full time care above the base rate for type of child care (licensed center, group home or family home) and age of child. All providers who maintain CYFD approved national accreditation status will be paid at the accredited rates for the appropriate age group and type of care. In order to continue at this accredited reimbursement rate, a provider holding national accreditation status must meet and maintain licensing standards and maintain national accreditation status without a lapse. If a provider holding national accreditation status fails to maintain these requirements, this will result in the provider reimbursement reverting to a lower level of reimbursement.

(1) Providers who receive national accreditation on or before December 31, 2014 from an accrediting body that is no longer approved by CYFD will no longer have national accreditation status, but will remain eligible to receive an additional $150.00 per child per month for full time care above the base rate for type of child care (licensed center, group home or family home) and age of child until December 31, 2017.

(a) In order to continue at this reimbursement rate until December 31, 2017 a provider holding accreditation from accrediting bodies no longer approved by CYFD must maintain licensing standards and maintain accreditation without a lapse;

(b) If the provider fails to maintain their accreditation, the provider reimbursement will revert to the base reimbursement rate unless they have achieved a FOCUS star level or regain national accreditation status approved by CYFD.

(2) The licensee shall notify the licensing authority within 48 hours of any adverse action by the national accreditation body against the licensee's national accreditation status, including but not limited to expiration, suspension, termination, revocation, denial, nonrenewal, lapse or other action that could affect its national accreditation status. All providers are required to notify the department immediately when a change in accreditation status occurs.

J. [~~Effective July 15, 2014~~] Upon the effective date of these regulations, the department will pay a differential rate per child per month for full time care above the base reimbursement rate to providers achieving higher Star levels by meeting FOCUS essential elements of quality as follows: [~~2+ star at $88.00 per month per child for full time care above the base reimbursement rate; 3-Star at $100.00 per month per child for full time care above the base reimbursement rate; 4-Star at $180.00 per month per child for full time care above the base reimbursement rate, and 5-Star at $250.00 per child per month for full time care above the base reimbursement rate.~~]

2+ Star FOCUS Child Care Centers, Licensed Family and Group Homes			
Infant	Toddler	Pre-school	School-age
$88.00	$88.00	$88.00	$88.00
3 Star FOCUS Child Care Centers, Licensed Family and Group Homes			
Infant	Toddler	Pre-school	School-age
$100.00	$100.00	$100.00	$100.00
4 Star FOCUS Licensed Family and Group Homes			
Infant	Toddler	Pre-school	School-age
$180.00	$180.00	$180.00	$180.00
5 Star FOCUS or CYFD approved national accreditation Licensed Family and Group Homes			
Infant	Toddler	Pre-school	School-age
$250.00	$250.00	$250.00	$250.00
4 Star FOCUS Child Care Centers			
Infant	Toddler	Pre-school	School-age
$280.00	$280.00	$250.00	$180.00
5 Star FOCUS or CYFD approved national accreditation Child Care Centers			
Infant	Toddler	Pre-school	School-age
$550.00	$550.00	$350.00	$250.00

K. In order to continue at [~~these~~] the FOCUS reimbursement rates, a provider must meet and maintain the most recent FOCUS eligibility requirements and star level criteria. If the provider fails to meet the FOCUS eligibility requirements and star level criteria the provider reimbursement will revert to the FOCUS criteria level demonstrated.

L. Differential rates determined by achieving higher star levels determined by AIM HIGH essential elements of quality will be discontinued effective December 31, 2017. The department will pay a differential rate to providers achieving higher star levels determined by the AIM HIGH essential elements of quality until December 31, 2017 as follows: 3-Star at $88.00 per month per child for full time care above the base reimbursement rate; 4-Star at $122.50 per month per child for full time care above the base reimbursement rate, and 5-Star at $150.00 per child per month for full time care above the base reimbursement rate. In order to continue at these reimbursement rates, a provider must maintain and meet most recent AIM HIGH star criteria and basic licensing requirements. If the provider fails to meet the requirements, this will result in the provider reimbursement reverting to the base reimbursement rate.

[~~K.~~] M. The department pays a differential rate equivalent to 5%, 10%, or 15% of the applicable full-time/part-time rate to providers who provide care during non-traditional hours. Non-traditional care will be paid according to the following charts:

	1-10 hrs/wk	11-20 hrs/wk	21 or more hrs/wk
After hours	5%	10%	15%

	1-10 hrs/wk	11-20 hrs/wk	21 or more hrs/wk
Weekend hours	5%	10%	15%

[~~L.~~] N. If a significant change occurs in the client's circumstances, (see Subsection G of 8.15.2.13 NMAC) the child care placement agreement is modified and the rate of payment is adjusted. The department monitors attendance and reviews the placement at the end of the certification period when the child is re-certified.

[~~M.~~] O. The department may conduct provider or parent audits to assess that the approved service units are consistent with usage. Providers found to be defrauding the department are sanctioned. Providers must provide all relevant information requested by the department during an audit.

[~~N.~~] P. Payments are made to the provider for the period covered in the placement agreement or based on the availability of funds, which may be shorter than the usual six to 12 month certification period. The client's certification period may be established for a period less than six months, if applicable to their need for care.

[8.15.2.17 NMAC - Rp, 8.15.2.17 NMAC, 02/14/05; A, 08/31/06; A/E, 08/15/07; A, 06/30/10; A/E, 11/01/10; Re-pr, 12/30/10; A/E, 12/01/11; Re-pr, 12/30/11; A, 7/1/12; A, 11/30/12; A, 7/1/13; A, 1/15/14; A, 7/15/14; A, 01/01/15; A, 09/29/15]

CHILDREN, YOUTH AND FAMILIES DEPARTMENT

This is an amendment to 8.26.2 NMAC, Sections 7 and 12 through 28, effective 9/29/2015

8.26.2.7 DEFINITIONS:

A. "Administrative appeal" is a formal hearing for families whose license has been revoked, suspended, or not renewed. The family has the opportunity to present evidence to an impartial hearing officer in accordance with CYFD's Administrative Appeals regulations 8.8.4 NMAC.

B. "Administrative review" is an informal process that may include an informal conference or record review, and does not create any substantive rights for the family.

C. "Adoptee" refers to any person who is the subject of an adoption petition.

D. "Adoption" is the establishment of a court sanctioned legal parental relationship between an adult and a child.

E. "Adoption subsidy" is a third party payment program that may include reimbursement for adoption related expenses, monthly maintenance payments, medical provisions, or payments for pre-approved expenses for pre-existing conditions.

F. "Adoption tax credit" is a federal or state tax credit program that may be available to families who adopt children from foster care.

G. "Adoptive home" refers to:

(1) a foster home licensed by PSD or a licensed child placement agency who chooses to adopt a foster child; or

(2) a family approved by a private agency or a licensed individual to adopt a child.

H. "Age appropriate activities and items" means an activity or item that is generally accepted as suitable for a child of the same age or level of maturity based on the child's cognitive, emotional, physical, social and behavioral capacities.

[~~H.~~] I. "Assessment" is the process of collecting information and conducting interviews with applicants by the licensing agent, and evaluating that information to determine the suitability of an applicant for a foster parent license.

[~~I.~~] J. "Best interest adoptive placement" is the adoption placement considered by PSD staff to be the most appropriate placement to meet the child's needs and best interest.

[~~J.~~] K. "Case management team" means the group of individuals with responsibility for implementing the case plan which may include PSD staff, parents or relatives, and the child if age appropriate.

[~~K.~~] L. "Community service providers" refers to organizations or individuals that provide support services to families, and may include CYFD contractors or any public or private agency or individual.

[~~**L. "Concurrent plan"** refers to case planning and legal practices providing reunification services while simultaneously implementing an alternative case plan should the reunification efforts be unsuccessful.~~]

M. "Concurrent plan" means a second permanency plan of adoption or guardianship in addition to the primary permanency plan of reunification.

[~~M.~~] N. "Consent to adoption" is a document [~~singed~~] signed by the adoptee if the child is [~~fourteen (14) years~~] 14 of age or older consenting to the adoption.

[~~N.~~] O. "Conversion adoption" refers to an adoption in which the child's foster parents have adopted the child.

[~~O.~~] P. "CYFD" means the New Mexico children, youth and families department.

[~~P.~~] Q. "Disruption" means the removal of a child by CYFD from a pre-adoptive home after an adoptive agreement has been signed, but prior to the finalization of the adoption.

[~~Q.~~] R. "Dissolution" means the legal termination of an adoption.

[~~R.~~] S. "Fictive kin" is a person not related by birth or marriage who has a significant relationship with the child.

[~~**S. "Foster care maintenance payment"** is the monthly reimbursement to foster care providers for costs associated with the child's room and board, and other expenses. Payments are determined by the child's age and level of care.~~

~~**T. "Foster parent"** refers to a person or persons licensed by CYFD or a licensed child placement agency to provide emergency, respite, stranger, relative or fictive kin, or treatment foster care services. The parent(s) may also be concurrently licensed to adopt. The term foster parent also refers to an adoptive parent whose adoption has not yet finalized.~~]

T. "Foster care provider" refers to a person or entity licensed by CYFD, licensed by another state's child welfare agency, or a licensed child placement agency to provide foster care services including respite, non-relative, relative, or treatment foster care.

U. "Foster child" as referred to as "child" herein, means a child who is placed in the care and custody of children, youth and families department protective services division either under the legal authorization of the Children's Code or through a voluntary placement agreement signed by the parent or legal guardian, or a child who is placed with a licensed child placement agency under the authority of the Child Placement Agency Licensing Act. If the court orders legal custody to a relative, person, facility, or agency other than the children, youth and families department protective services division, the child is not a foster child of protective services division.

V. "Foster home license" is the document which bears the name or names and address or addresses of those who are foster parents for the protective services division or licensed child placement agency. The license displays the ages and number of foster children the licensees are authorized to care for and the date such authorization begins and ends. The license shall bear the signature of the authorized person who issued the license.

W. "Foster parent" is the person named on the license issued by protective services division or a licensed child placement agency who is authorized to care for foster children. Throughout this policy, the term foster parent also refers to an adoptive parent whose adoption has not yet finalized.

[~~U.~~] X. "Foster parent bill of rights" is a statement of PSD's responsibilities to foster parents.

[~~V.~~] Y. "Freed for adoption" means all parental rights are terminated and all time for appeal is exhausted.

[~~W.~~] Z. "Home study" is the final written document that results from the assessment process to determine the suitability of an applicant for a foster parent license.

[~~X.~~] AA. "Individualized adoption plan (IAP)" is an individualized and specific recruitment plan developed by PSD staff for children who have a plan of adoption.

[~~Y.~~] BB. "Initial relative or fictive kin assessment" is an in-home assessment of relative or fictive kin completed by the child's caseworker to determine suitability for provisional licensure.

[~~**Z. "Level 1 foster care"** is the basic level of foster care services. Every child, except for those with documented serious medical or behavioral conditions, enters foster care as a level1.~~

~~**AA. "Level 2 foster care"** is for children requiring a higher level of care, structure, or supervision than would be required for a child of similar age development. Level 2 requires a PSD assessment and PSD supervisory approval.~~

~~**BB. "Level 3 foster care"** is for children requiring a significantly high level of care and is generally an alternative to institutional care. Level 3 requires a medical or psychological clinical assessment and PSD deputy director approval.~~]

CC. "Life book" is a combination of documents that remains with the child that may include photos, letters, correspondence, development milestones, memorabilia and other items related to the child's life.

DD. "Maintenance payments" are payments designed to reimburse foster care providers for the cost of food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, and reasonable travel required to address the child's needs. Maintenance payments are not considered income.

[~~**DD.**~~] **EE. "Non-conversion adoption"** refers to an adoption in which a child is placed in a pre-adoptive home, for the purpose of adoption, which did not serve as a foster home for the child.

[~~**EE.**~~] **FF. "Non-recurring adoption expenses (NRAE)"** are reasonable and necessary adoption fees that may include transportation, food and lodging for the child and adoptive parent, court costs, attorney fees and other expenses which are directly related to the legal adoption of a child with special needs and which have not been reimbursed from other sources or funds.

[~~**FF.**~~] **GG. "Post adoption contact agreement (PACA)"** is an agreement between the birth and adoptive families regarding contact between them after the adoption has been finalized.

[~~**GG.**~~] **HH. "Post placement support services"** are services intended to strengthen families and support adoptive placement provided by PSD staff, or community service providers to children in custody and their pre-adoptive families to enhance the family's capacity to care for the child, assure the stability of the placement, and help the family meet the requirements to finalize the adoption.

[~~**HH.**~~] **II. "Post decree support services"** are services provided by PSD staff or community service providers to children and families who have finalized an adoption to enhance the family's capacity to care for the child and support family functioning.

[~~**H.**~~] **JJ. "Pre-adoptive home"** refers to a family who has signed the adoption agreement to adopt a foster child, but the adoption has yet to finalize.

[~~**JJ.**~~] **KK."Protective services division (PSD)"** refers to the protective services division of the children, youth and families department, and is the state's designated child welfare agency.

[~~**KK.**~~] **LL. "PSD custody"** means custody of children as a result of an action filed under the [~~New Mexico Children's Code 32A-4-1 et seq., NMSA 1978 or 32A-3B-1 et seq., NMSA 1978.~~] New Mexico Children's Code, Sections 32A-4-1 NMSA 1978 or 32A-3B-1 NMSA 1978.

MM. "Reasonable and prudent parent standard" means the standard of care characterized by careful, nurturing and thoughtful decision-making by the foster parent or out of home provider that is intended to maintain a child's health, safety, culture or cultural identity and best interests while encouraging the child's emotional, social and developmental growth.

[~~**LL. "Relative"** refers to mothers, fathers, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, first cousins, mother-in-laws, father-in-laws, sister-in-laws and brother-in-laws, as well as fictive kin.~~

~~**MM. "Surrogate parent":**~~

~~**(1)** a person, other than the child's case worker, appointed by the New Mexico department of health family, infant and toddler program director to represent the special needs of a child in all matters related to the early intervention and evaluation assessment and treatment for the child in the event the parent is unable or unwilling to act in that capacity; or~~

~~**(2)** a person, other than the child's case worker, appointed by the court who stands in for the parent of a student who qualifies for special education to protect the student's educational rights, and act as the student's advocate in the education decision making process in the event the parent is unable or unwilling to act in the capacity.~~]

NN. "Relative" means a person related to another person by birth, adoption or marriage within the fifth degree of consanguinity.

[~~**NN.**~~] **OO. "Transition calendar"** refers to the calendar which is developed once the family has accepted the child for an adoptive placement.

[~~**OO.**~~] **PP. "Traveling file"** includes copies of the medical and educational records related to the foster child. The traveling file shall remain with the child.

[8.26.2.7 NMAC - Rp, 8.26.2.7 NMAC, 5/29/09; A, 9/29/15]

8.26.2.12 ROLES AND RESPONSIBILITES OF FOSTER PARENTS:

A. Foster parents are considered integral members of a professional team dedicated to the critical responsibility of providing safety, permanency and well-being for children who have been abused or neglected. As such, foster parents shall be active participants in case planning for foster children. The foster parent shall work closely with PSD staff to implement the service plan for each foster child including visitation for each foster child.

B. Foster families support the preservation of connections for foster children in their care. Preserving connections may include the development of a long-term supportive relationship with foster children and their foster families even after the child has been discharged from care.

C. [~~Foster care providers shall adhere to applicable PSD policy and procedure.~~] Foster care providers shall adhere to applicable PSD policy and procedure, including the reasonable and prudent parent standard.

D. Foster parents shall not use words, language, gestures, either directed at the foster child or made within a foster child's sight or hearing, which disparage the foster children's parents, relatives or the child's cultural heritage. Foster parents shall encourage the child to recognize and accept such strengths and achievements of their family as honestly identified.

E. Prohibited forms of discipline shall include, but are not limited to the following: corporal punishment such as shaking, spanking, hitting, whipping, or hair or ear pulling; isolation; forced to exercised; denial of food, sleep or approved visits or contact with parent; verbal assaults which subject the child to ridicule or which belittle the child or the child's family, gender, race, religious preference, sexual orientation or cultural identity. The child shall not be excluded from the foster family and shall not be threatened with exclusion from the foster

home as punishment. The child shall not be locked in a room or closet.

F. The foster parent may serve as a [~~surrogate parent~~] the child's educational decision maker to protect the foster child's educational rights and act as the student's advocate in the educational decision making process if appointed by the court.

G. When appointed by the New Mexico department of health family, infant and toddler program director, the foster parent may serve as a [~~surrogate parent~~] the child's decision maker to represent the special needs of a child in all matters related to the early intervention and evaluation assessment and treatment for the child in the event the parent is unable or unwilling to act in that capacity.

H. Foster parents shall return all of a child's belongings when he or she moves to another placement, including the return home.

I. [~~Foster parents shall not release a foster child to the custody of any person, including the child's biological parent or any relative, without the authorization of PSD. The only exception to this rule is that foster children may be surrendered to the custody of a law enforcement officer.~~] Foster parents shall not release a foster child to anyone without the authorization of PSD, except when pursuant to the reasonable and prudent parent standard defined at 8.26.2.7 MM NMAC. Foster children may also be surrendered to the custody of a law enforcement officer.

J. Foster parents shall adhere to all statutes and regulations applicable to the provision of foster care, including but not limited to child labor laws, public health laws, mandatory school attendance, and motor vehicle laws.

K. Foster parents shall provide PSD with any documents they obtain with respect to the foster child's legal status, health needs or care, service planning, school progress or other relevant documents.

L. Foster parents shall maintain copies of all educational and medical documents related to the foster child in a traveling medical and educational file that shall remain with the child if the child is moved.

M. Foster parents, in cooperation with PSD staff, shall create or maintain a life book for each child in their care that shall remain with the child if the child is moved.

N. The foster parent shall maintain the confidentiality of all information regarding the foster child and the child's family pursuant to the New Mexico Children's Code 32A-4-33 NMSA 1978. [~~The provision requires that, among other things, all records or information regarding a part to a neglect or abuse proceeding, including but not limited to medical, social, and psychological records regarding the child's educational needs, be kept confidential, and that the unlawful public disclosure of such confidential information is a misdemeanor under New Mexico criminal law.~~] The unlawful public disclosure of such confidential information is a misdemeanor under New Mexico criminal law.

O. Foster parents shall immediately report any signs, symptoms indications or risk of abuse or neglect to any child to PSD statewide central intake (SCI) or law enforcement.

P. [~~With PSD approval, foster parents may consent to the use of their own personal vehicle by a foster child, and shall assume all civil and financial liabilities applicable to the foster child's operation of a motor vehicle. Foster parents shall provide to PSD written documentation that all requirements have been met, including insurance coverage for any vehicle driven by the foster child. Liability may extend to the foster parents even after the foster child has left the home.~~] Pursuant to the reasonable and prudent parent standard, foster parents may consent to the use of their own personal vehicle by a foster child, and shall assume all civil and financial liabilities applicable to the foster child's operation of a motor vehicle. Foster parents shall provide to PSD written documentation that all requirements have been met, including insurance coverage for any vehicle driven by the foster child.

[~~**Q.** Foster parents may not permit foster children to work without approval from PSD.~~]

[~~**R.**~~] **Q.** Foster parents shall complete the foster parent report form provided by PSD regarding the child's well-being and progress and submit it to their PSD worker monthly.

[8.26.2.12 NMAC - Rp, 8 NMAC 27.3.25 & 8.27.2.29 NMAC, 5/29/09; A, 9/29/15]

8.26.2.13 APPLICATION OF THE REASONABLE AND PRUDENT PARENT STANDARD

A. PSD shall make efforts to normalize the lives of children in PSD's custody and to empower caregivers to approve a child's participation in activities, based on the caregiver's own assessment using a reasonable and prudent parent standard, without prior approval of PSD.

B. Foster care providers shall not require advance permission from PSD to apply the reasonable and prudent parent standard to decisions about the care of a child.

C. In applying the reasonable and prudent parent standard, the foster parent shall consider the following:

(1) the desires of the child including, but not limited to, cultural identity, spiritual identity, gender identity, and sexual orientation;

(2) the child's age, maturity and developmental level;

(3) potential risk factors and the appropriateness of the activity;

(4) the best interests of the child based on the foster care provider's knowledge of the child;

(5) the importance of encouraging the child's emotional and developmental growth;

(6) the terms of any court orders and any case plan applying to the child;

(7) the values and preferences of the child's biological parent or parents, if appropriate;

(8) whether the decision would bring about a permanent (e.g. tattoo) rather than a transient change to the child.

(9) the importance of providing the child with the most safe and affirming family-like and culturally relevant living experience possible;

(10) the legal rights and responsibilities of the child, including the youth bill of rights and responsibilities;

(11) Americans with Disabilities Act

D. Age and developmentally appropriate activities that may be the subject of decisions under the reasonable and prudent parent standard include, but are not limited to, the following:

(1) a cultural, social, or enrichment activity or support that fosters positive identity development;

(2) a sleepover of one or more nights;

(3) participation in sports or social activities, including related travel;

(4) obtaining a driver's license and conditions for driving of a vehicle;

(5) allowing the

child to travel in other person's vehicle;

(6) possession and use of a cell phone;

(7) obtaining a job or working for pay (e.g. babysitting, yard work, etc.)

(8) recreational activities (including, but not limited to, such activities as boating, swimming, camping, hunting, cycling, hiking, horseback riding).

E. Foster parents may consult with the PSD worker when uncertain or uncomfortable with a decision under their consideration.

F. In situations in which a child age 14 or older disagrees with a decision made under the prudent parent standard, the child shall request a review of the decision in writing. The decision shall be reviewed by a neutral three-person panel. This process does not preclude any party from seeking a court order regarding the decision.

G. PSD shall seek appropriate statutory change to ensure that foster parents and other substitute care providers are shielded from liability when they act in accordance with the reasonable and prudent parent standard. In the meantime, CYFD will hold harmless and defend its licensed foster care providers in situations where they have acted and made decisions in accordance with the reasonable and prudent parent standard.

[8.26.2.13 NMAC - N, 9/29/15]

[~~8.26.2.13~~] 8.26.2.14 HEALTH SERVICES FOR FOSTER CHILDREN:

A. The foster parent shall observe daily the foster child's behavior and signs of emotional or physical health problems. Any concerns shall be reported to PSD immediately.

B. There shall be a designated license physician and dentist for each child so that a coordinated plan of care is assured. Foster parents shall obtain medical attention for any sick or injured child. Foster parents, in their role as an adjunct representative of state government, shall not rely solely on spiritual or religious healing for foster children.

[8.26.2.14 NMAC - Rn, 8.26.2.13 NMAC, 9/29/15]

[~~8.26.2.14~~] 8.26.2.15 EDUCATIONAL SERVICES FOR FOSTER CHILDREN:

A. [~~Parents~~] Foster parents shall assist PSD in meeting the child's educational requirements, and in transporting the child to school he or she attended at the time of placement when necessary and reasonable. Foster parents shall ensure that the foster child attend school. Foster children may not be home schooled.

B. Foster parents shall actively advocate for the foster child's interest in the school setting, including seeking evaluations of the child's abilities and placement in any special education programs appropriate to the child's needs. Foster parents shall attend school conferences and activities when appropriate. Foster parents shall report significant educational information to PSD.

[8.26.2.15 NMAC – Rn & A, 8.26.2.14 NMAC, 9/29/15]

[~~8.26.2.15~~] 8.26.2.16 FOSTER CARE MAINTENANCE PAYMENTS:

A. Reimbursement: Foster care providers shall receive reimbursement for the care and support of a child in PSD custody placed in their home. Rates are established through legislative appropriation based on the age and needs of the child.

B. Foster parents receiving CYFD foster care and support maintenance payments shall use these funds for the care and support of the identified child in their care, and shall not be considered a source of income and is not recognized as income when filing taxes.

C. PSD shall advise foster parents that they should consult a tax advisor to determine if foster children in their home may be considered eligible for a federal tax credit under the Internal Revenue Code.

[8.26.2.16 NMAC – Rn, 8.26.2.15 NMAC, 9/29/15]

[~~8.26.2.16~~] 8.26.2.17 MONITORING AND SUPPORT:

A. PSD monitors foster and adoptive homes licensed by PSD.

B. At a minimum, when a child is placed in the home, PSD placement staff shall:

(1) visit the foster or adoptive parent in the home within [~~five (5) days~~] five of each new placement;

(2) conduct a home visit to the foster or adoptive parent once a month for the first [~~three (3)~~] three months following placement;

(3) conduct a home visit to the foster or adoptive parent at least every [~~three (3)~~] three months, and make phone contact at least every [~~thirty (30)~~] 30 days thereafter.

C. At a minimum, when a child is not placed in the home, PSD placement staff shall conduct a home visit to the foster parent every [~~three (3)~~] three months and have monthly phone contact.

D. PSD receives documents and investigates all reported licensing violations and reports of maltreatment in foster care.

E. PSD placement staff may continue to have contact with a foster family it license that is under investigation for allegations of child abuse or neglect, but is prohibited from action in such a manner that may interfere with any ongoing civil or criminal investigation.

F. PSD may develop and implement a professional development plan to include training and professional development opportunities to address parenting needs, or licensing and policy infractions. At no time is the safety of a foster child compromised to allow for a foster parent to participate in a professional development plan.

G. Relative foster homes receive the dame monitoring and support afforded to non-relative foster homes.

H. Additional support services may be available from community service providers or PSD staff.

[8.26.2.17 NMAC - Rn & A, 8.26.2.16 NMAC, 9/29/15]

[~~8.26.2.17~~] 8.26.2.18 INVESTIGATIONS OF ABUSE AND NEGLECT REFERRALS AND POLICY VIOLATIONS:

A. Any CYFD employee suspecting child abuse or neglect in a foster parent home makes a report as set forth in Protective Services Intake policy, [~~8.10.2.14 NMAC.~~] 8.10.2 NMAC. PSD staff who suspects, has knowledge of, or receives an allegation about a foster parent violating CYFD policy or licensing regulations shall immediately notify the placement supervisor.

B. Investigations of abuse and neglect referrals in foster homes:

(1) PSD shall investigate all screened-in reports of allegations of abuse or neglect regarding children in accordance with protective services investigation policy and procedure.

(2) If a screened-out report involves a child in PSD custody, the child's worker shall conduct a safety assessment of the placement.

(3) No new placement may be made in the home during a pending investigation. Existing

placements in the home shall be evaluated for safety. The decision as to whether to maintain placement shall depend on the continued safety of any child.

(4) Based upon the results of the investigation of the abuse or neglect referral, PSD may take one or more of the following actions:

(a) continue the placement, implementing a professional development and safety plan, if appropriate;

(b) terminate the placement; or

(c) determine if the family shall continue to be licensed as a PSD foster family.

C. Investigations of CYFD policy violations:

(1) The placement worker shall assess any allegations that the family has violated CYFD policy or licensing regulations.

(2) Based upon the results of the investigation of the alleged policy violation, PSD may take one or more of the following actions:

(a) continue the placement, implementing a professional development and safety plan, if appropriate;

(b) terminate the placement; or

(c) determine if the family shall continue to be licensed as a PSD foster family.

D. PSD shall notify the foster parent in writing, by return of receipt mail, of the results and PSD actions of any substantiated abuse and neglect investigation or policy violations.

E. The results of any substantiated abuse and neglect investigation or policy violation, which is not the subject of court action, may be reviewed through CYFD's administrative review process. The foster family may request an administrative review within [~~(10)~~] ten days of receiving the written notice.

[8.26.2.18 NMAC - Rn & A, 8.26.2.17 NMAC, 9/29/15]

[~~8.26.2.18~~] 8.26.2.19 CRISIS INTERVENTION:

A. PSD staff may develop and implement a crisis intervention plan to prevent the disruption of a foster or adoptive placement and strengthen the family's capacity to care for the child.

B. If disruption is unavoidable, PSD staff focuses on minimizing the trauma to the child. After a disruption, PSD staff re-assesses the permanency plan for the child and child's placement and [~~services~~] service needs.

[8.26.2.19 NMAC - Rn & A, 8.26.2.18 NMAC, 9/29/15]

[~~8.26.2.19~~] 8.26.2.20 POST ADOPTION CONTACT AGREEMENT (PACA): PSD facilitates the negotiation of post adoption contact agreements.

[8.26.2.20 NMAC - Rn, 8.26.2.19 NMAC, 9/29/15]

[~~8.26.2.20~~] 8.26.2.21 BEST INTEREST ADOPTION PLACEMENT:

A. When a child's permanency plan becomes adoption, the child is referred to a PSD adoption consultant for the purposes of identifying a potential adoptive family. If an adoptive family is not identified, an individualized adoption plan is developed for the child.

B. The best interest of a child is paramount in identifying an adoptive family for a child. PSD makes reasonable efforts to place siblings together in the same adoptive home, unless PSD documents that such a joint placement would be contrary to the safety and well-being of any of the children in the sibling group. PSD will not separate siblings solely because an adoptive placement is available for one or more children, but not the entire group.

C. When a family is identified, placement staff will schedule a best interest placement staffing.

D. Children aged [~~fourteen (14)~~] 14 years or older must consent to the adoption.

E. The placement of a child shall not be delayed or denied based on the race, color, sex, gender identity, sexual orientation, mental or physical handicap, ancestry, or national origin of the adoptive parent or child involved.

F. For Native American children, the Indian Child Welfare Act (ICWA) adoption preferences shall be followed pursuant to the Adoption Act, 32A-5-5 NMSA 1978.

[8.26.2.21 NMAC - Rn & A, 8.26.2.20 NMAC, 9/29/15]

[~~8.26.2.21~~] 8.26.2.22 FULL DISCLOSURE:

A. Prior to placement, PSD staff shall provide full disclosure about the child to the foster or adoptive family, and continue to provide full disclosure throughout the case and after finalization of the adoption, provided the information does not reveal information that would identify the biological family. Pursuant to the [~~Adoption Act, 32A-5-3 (N) NMSA 1978,~~] New Mexico Children's Code, Section 32A-5-3 N NMSA 1978, full disclosure information includes:

(1) health history;

(2) psychological history;

(3) mental history;

(4) hospital history;

(5) medication history;

(6) genetic history;

(7) physical description;

(8) social history;

(9) placement history; and

(10) education.

B. All records, whether on file with the court, an agency, PSD, an attorney or other provider or professional services in connection with an adoption are confidential pursuant to the [~~Adoption Act, 32A-5-8 NMSA 1978.~~] New Mexico Children's Code, Section 32A-5-8 NMSA 1978. A person who intentionally and unlawfully release any information or records closed to the public pursuant to the Adoption Act or releases or make other unlawful use of records in violation of that act is guilty of a petty misdemeanor.

C. Documentation provided for the purpose of full disclosure shall remain the property of the person making the full disclosure when a prospective adoptive parent decides not to accept a placement. Immediately upon refusal of the placement, the prospective adoptive parent shall return all full disclosure documentation to the person providing the full disclosure. A prospective adoptive parent shall not make public any confidential information received during the full disclosure process, but may disclose such information only as necessary to make an informed placement decision, or to the child's guardian ad litem or youth attorney.

[8.26.2.22 NMAC - Rn & A, 8.26.2.21 NMAC, 9/29/15]

[~~8.26.2.22~~] 8.26.2.23 PRE-PLACEMENT ACTIVITIES FOR NON-CONVERSION ADOPTIONS:

A. PSD placement staff in coordination with the child's worker shall develop a calendar for the transition of the child to the adoptive home, except in the event a foster parent decide to adopt

the child.

B. PSD staff and the adoptive family shall review and sign a placement agreement when the child is placed in the home.

C. Placement staff becomes responsible for the case form placement in the adoptive home until finalization of the adoption.

[8.26.2.23 NMAC - Rn & A, 8.26.2.22 NMAC, 9/29/15]

[~~8.26.2.23~~] 8.26.2.24 FOSTER HOME ADOPTIONS:

A. PSD shall attempt to place foster children with concurrent plans of adoption in foster homes which have been identified as concurrent families.

B. PSD completes the pre-placement home study for foster parents and treatment foster parents who have been selected as adoptive parent for children in PSD custody.

[8.26.2.24 NMAC - Rn, 8.26.2.23 NMAC, 9/29/15]

[~~8.26.2.24~~] 8.26.2.25 ADOPTION ASSISTANCE:

A. [~~Adoption assistance is available to any family who adopts an eligible child through CYFD.~~] The purpose of adoption assistance is to support the adoption of a foster child who meet special-needs criteria by providing financial assistance or medical coverage to support families in meeting the needs of the child. PSD verifies whether a child has special needs according to the following criteria:

(1) the child cannot or should not be returned to the home of the parents;

(2) there is documentation of at least one of the following factors or conditions that make it reasonable to conclude that the child cannot be placed for adoption without providing adoption assistance:

(a) the child is age five or older, or

(b) the child has a diagnosed physical, developmental, or psychological or emotional condition requiring medical or mental health intervention, or

(c) the child is a member of a minority group, or

(d) the child is part of a sibling group that will be placed together; and

(3) a reasonable, but unsuccessful, effort has been made to place the child without adoption assistance, unless such effort would be against the best interests of the child

B. [~~PSD determines if a child is eligible to receive state or federal adoption assistance based upon federal of state established criteria. PSD informs the adoptive family of the adoptee's eligibility for adoption assistance.~~] A child may be eligible for state funded adoption assistance or Title IV-E adoption assistance. If a child is not determined to meet special needs criteria, then the child shall not be eligible for any adoption assistance.

C. Initial adoption agreement:

(1) PSD shall negotiate adoption assistance based on the family's circumstances and any special needs of the child. The monthly adoption maintenance payment may not exceed the maximum monthly amount that was paid for the child in foster care. [~~Where a private agent has licensed a foster family and the foster family has determined to adopt, the adoption subsidy shall be negotiated in the same manner as any other subsidy.~~]

(2) Types of assistance available:

(a) Maintenance: Monthly adoption assistance maintenance payments for the eligible child shall be utilized to meet the child's existing day to day needs and is not considered income. Monthly adoption assistance maintenance payments are terminated on the child's eighteenth birthday. [~~Adoption assistance may be extended until the child is twenty-one (21) years of age, if the child is certified medically fragile by the New Mexico department of health.~~]

(b) Medical: Medical adoption assistance may be made on behalf of a child and shall cover only those pre-approved, pre-existing conditions that are not covered by the family's private or group medical insurance or medicaid, and does not include co-payments or deductible for which the patient is responsible. Medicaid is available in accordance with the laws, regulations or procedures of the state in which the child resides. Medical assistance may be extended until the child is 21 years of age, if the child is certified medically fragile by the New Mexico department of health.

(3) Interstate placement: When the adoption of the child involves interstate placement, the state that enters into the adoption assistance agreement shall be responsible for paying the non-recurring adoption expenses of the child. In cases in which there is interstate placement, but no agreement for adoption assistance, the state in which the final adoption decree is issued shall be responsible for paying the non-recurring expenses if the child meets the requirements.

(4) With placement worker approval, the adoptive family may be reimbursed for non-recurring adoption expenses (NRAE) up to $2000.00 per child in PSD custody. NRAE may include transportation and other reasonable expenses such as lodging and food for the child and adoptive parents that are not otherwise reimbursed. NRAE are not reimbursable in the event the adoption does not finalize. There is no income eligibility requirement for adoptive parents in determining whether payments for non-recurring expenses of adoption shall be made. However, parents cannot be reimbursed for out-of-pocket expenses for which they have otherwise been reimbursed.

(5) An adoptive family may receive a one-time only subsidy for legal services leading to the finalization of an adoption based on the adoption case regardless of number of siblings.

D. Prior to adoption finalization, the placement worker and the adoptive family shall sign the adoption assistance agreement that specifies adoption assistance and NRAE. Each Title IV-E subsidy agreement shall be completed and signed prior to the adoption finalization to be valid.

E. By signing the adoption assistance agreement, the adoptive parent agrees to immediately notify PSD of any of the changes listed below:

(1) the adoptive parent is no longer legally responsible for the child;

(2) the adoptive parent is no longer financially responsible for the child;

(3) change of address, phone numbers, or email addresses;

(4) change in the child's name and social security number;

(5) change in the family's needs or circumstances;

(6) change in electronic funds deposit information;

(7) the adoptive child no longer lives with the adoptive parents; or

(8) the death of an adoptive child.

F. Annual contact: On an annual basis PSD shall provide the adoptive family a form to complete and return to PSD attesting to the following:

(1) the family continues to have financial and legal responsibility for the child; or

(2) that the adopted child is a full time elementary or secondary student (or has completed secondary school). If the child is incapable of attending school on a full time basis due to medical condition, the adoptive parent must submit to PSD regularly updated medical information to support such incapability. The parent must certify one of the following:

(a) that the child is enrolled (or is in a timely process of enrolling) in an institution that provides elementary or secondary education and meets school attendance requirements in accordance with state law;

(b) that the child is being home schooled in an elementary or secondary school program that complies with state law; or

(c) that the child is in an independent study elementary or secondary school program that complies with state law and is administered by the local school or school district.

(3) the child is or is not covered by private medical insurance.

G. Adoption assistance shall be terminated based upon any of the following events:

(1) the child reaches [~~eighteen (18)~~] 18 years of age, except in the event of medically fragile certification;

(2) PSD determines that the adoptive family is no longer legally responsible for the child; or

(3) PSD determines that the adoptive family is no longer providing any support to the child.

H. PSD shall notify the adoptive family in writing, by return of receipt mail, of any decision to reduce, change, suspend or terminate an adoption subsidy. The adoptive parent may request an administrative appeal within ten [~~(10)~~] days of receiving notification of the decision to reduce, change, suspend or terminate adoption subsidy.
[8.26.2.25 NMAC - Rn, 8.26.2.24 NMAC, 9/29/15]

[~~8.26.2.25~~] 8.26.2.26 POST PLACEMENT ADOPTION SUPPORT SERVICES:

A. PSD shall provide support services to the child and adoptive family. Support services are intended to assist the family in adjusting, enhance the family's capacity to care for the child, and strengthen the family.

B. PSD shall develop a case plan with all families adopting children in PSD custody.

C. During this period PSD shall provide information to the adoptive family regarding requirements for legal finalization of the adoption including the family's selection of an attorney, name change of the child, and required consent of the child, if the child is over [~~fourteen (14)~~] 14 years of age.

D. PSD shall assess and document the status of placement until finalization of the adoption.

E. If the adoptive family and child, with PSD approval, move out of state prior to the finalization, PSD shall initiate a referral through the interstate compact on the placement of children to request appropriate post placement services and written reports from the receiving state. PSD shall retain jurisdiction and responsibility for all case activities until finalization.
[8.26.2.26 NMAC - Rn & A, 8.26.2.25 NMAC, 9/29/15]

[~~8.26.2.26~~] 8.26.2.27 ADOPTION FINALIZATION:

A. PSD establishes time frames for finalization based on the age and needs of the child pursuant to the [~~Adoption Act, 32A-5-25 A~~] New Mexico Children's Code, Section 32A-5-25 A NMSA 1978 and the time frames for court approval of finalization pursuant to 32A-5-36 F(6) NMSA 1978.

B. The family may file the adoption petition according to their state of residence or in New Mexico.

C. Placement staff compiles and submits post placement reports to the court for all PSD children and children placed for adoption in New Mexico through the interstate compact for the placement of children.
[8.26.2.27 NMAC - Rn & A, 8.26.2.26 NMAC, 9/29/15]

[~~8.26.2.27~~] 8.26.2.28 POST DECREE SUPPORT SERVICES:

A. Upon finalization, PSD shall provide information regarding resources to support the family in their community. Placement staff may provide direct support services or make referrals to community service providers in order to support, strengthen, and enhance the family's capacity to care for the child to prevent disruption or dissolution.

B. PSD shall respond to adult adoptee requests for information pursuant to the [~~Adoption Act, 32A-5-40 E NMSA 1978.~~] New Mexico Children's Code, Section 32A-5-40 E NMSA 1978.
[8.26.2.28 NMAC - Rn & A, 8.26.2.27 NMAC, 9/29/15]

DEPARTMENT OF GAME AND FISH

The State Game Commission repeals its rule entitled Game and Fish Licenses/Permits, 19.30.9 NMAC (filed 07/16/2001), and replaces it with 19.30.9 NMAC Game and Fish Licenses/Permits, effective 09/29/2015.

DEPARTMENT OF GAME AND FISH

TITLE 19 NATURAL RESOURCES AND WILDLIFE
CHAPTER 30 WILDLIFE ADMINISTRATION
PART 9 GAME AND FISH LICENSES/PERMITS

19.30.9.1 ISSUING AGENCY: New Mexico Department of Game and Fish.
[19.30.9.1 NMAC - Rp, 19.30.9.1 NMAC, 9-29-15]

19.30.9.2 SCOPE: License vendors and individuals utilizing the special use of wildlife licenses and permits.
[19.30.9.2 NMAC - Rp, 19.30.9.2 NMAC, 9-29-15]

19.30.9.3 STATUTORY AUTHORITY: 17-1-14, 17-3-5, 17-3-7, and 17-3-12 NMSA 1978 provide that the New Mexico state game commission has the authority to establish rules and regulations that it may deem necessary to carry out the purpose of Chapter 17, NMSA 1978 and all other acts pertaining to protected species.
[19.30.9.3 NMAC - Rp, 19.30.9.3 NMAC, 9-29-15]

19.30.9.4 DURATION: Permanent.
[19.30.9.4 NMAC - Rp, 19.30.9.4 NMAC, 9-29-15]

19.30.9.5 EFFECTIVE DATE: September 29, 2015, unless a later date is cited at the end of a section.

[19.30.9.5 NMAC - Rp, 19.30.9.5 NMAC, 9-29-15]

19.30.9.6 OBJECTIVE: Establishing bonding requirements for license vendors, vendor application requirements, the vendor fee per license, and certain licenses, permits, certificates and fees for special uses of wildlife.
[19.30.9.6 NMAC - Rp, 19.30.9.6 NMAC, 9-29-15]

19.30.9.7 DEFINITIONS:

A. "Vendor" shall mean any owner(s) of a private or public business concern authorized by the New Mexico department of game and fish to sell license documents.

B. "License document(s)" shall mean any license form that authorizes a person to legally hunt, fish, or trap in New Mexico.
[19.30.9.7 NMAC - Rp, 19.30.9.7 NMAC, 9-29-15]

19.30.9.8 LICENSE VENDORS:

A. Vendor eligibility, procedures and bonding requirements:

(1) Each vendor shall follow the procedures set forth in the most current New Mexico department of game and fish license vendor manual and agreement.

(2) Bonding requirements shall be established and maintained by the director of New Mexico department of game and fish. A surety bond shall be required of vendors who elect to remit the statutory license and permit fees pursuant to 17-3-7(D) NMSA 1978.

(3) A vendor may obtain a waiver of the bonding requirement subject to the following conditions:

(a) A vendor must participate in the department's web-based sales system and submit payment when the total amount due (including license and vendor fees) to the department reaches $5,000 or every two weeks, whichever comes first.

(b) A new vendor, or a vendor who has been inactive for one year or more, shall submit a vendor application form available from the department; a current credit score (provided by a credit reporting company), and shall be subject to a background check conducted by the department.

(c) An applicant with a credit score less than the average for the credit reporting company submitted will be ineligible to obtain a waiver of the bonding requirements.

(d) An applicant who has a felony conviction or who has had their hunting, fishing or trapping license privileges currently revoked or suspended or who has an outstanding civil assessment owed to the department is not eligible to obtain a waiver of the bonding requirements.

(4) A vendor must be party to a current license vendor agreement with the department on a form approved by the department.

(5) If a vendor is more than five days delinquent in its payment, its privileges to accept cash for department licenses and permits shall be immediately suspended, and the department shall only reactivate the vendor's full license sale privileges once payment is received in full.

(6) A vendor that is delinquent more than three times in any twelve month period shall have its privileges to sell department licenses and permits evaluated by the director, who shall determine if the vendor may retain those privileges, and whether the department will continue to waive the bonding requirement.

B. Director's Authority

(1) The director may suspend, restrict or place conditions on a license vendor's privileges if the vendor is found to be in violation of their vendor agreement or delinquent in their financial obligation to the department. If such a determination is made, a notice of the suspension, restriction(s), or condition(s) shall be sent to the vendor within 10 days of the director's determination.

(2) An applicant or vendor who wishes to challenge any eligibility determination under this rule, may appeal to the director whose determination will be final and not subject to further appeal.

C. Vendor fee:

(1) The department will pay the vendor fees earned by the vendor for the previous month license sales, no later the 10th business day of the next month, to the vendor,

(2) The vendor shall be required to be registered in the state of New Mexico's central accounting system.
[19.30.9.8 NMAC - Rp, 19.30.9.8 NMAC, 9-29-15]

Continued On Following Page

19.30.9.9 ESTABLISHING CERTAIN LICENSES, PERMITS, CERTIFICATES AND FEES:

Type	Further description	Fee
Certificate of application	NM resident draw application fee	$7.00
	Non-resident draw application fee	$13.00
Wildlife conservation stamp	Share with wildlife	$10.00
Duplicate license		$6.00
Landowner authorization certificate		$9.00
Additional antelope permit tag		$25.00
Migratory bird permit	Harvest information program (HIP)	$0.00
Big game depredation damage stamp	NM resident	$3.00
	Non-resident	$10.00
Public land user stamp	Habitat stamp	$5.00
Bait dealers		$21.00
Commercial fishing		$25.00
Importation fish	Annual application processing fee	$25.00
	Additional stocking and shipment fee	$6.00
Retention		$1.25
Transportation		$0.00
Triploid grass carp		$25.00
Airborne hunting		$10.00
Class A lake aquaculture/recirculating water system	Up to 75 fish or 750 gallons	$20.00
	76 to 150 fish or 751 to1500 gallons	$40.00
	Over 150 fish or over 1500 gallons	$100.00
Call pen		$15.00
Class A lake		$101.00
Class A lake	Additional lake	$26.00
Class A park		$501.00
Commercial collecting	Reptiles and amphibians	$50.00
Educational use of wildlife	Application, renewal or amendment	$15.00
Falconry	Application or renewal for 3 years	$25.00
Field trial/importation		$15.00
Game bird propagation		$10.00
Protected mammal		$10.00
Scientific use of wildlife	Application	$15.00
	Renewal or amendment	$15.00
Shooting preserve		$200.00
Zoo	No fee	$0.00

Importation non-domesticated animals per calendar year (1/1 to 12/31) except protected ungulates, game birds, fish or other	Class 1 importation of 1 to 5 animals	$25.00
	Class 2 importation of 6 to 99 animals	$75.00
	Class 3 importation of greater than 100 animals	$300.00
Importation other	One time import (i.e., temporary importation, exhibition, game birds, restoration/recovery, etc.)	$20.00
Importation protected ungulate	Initial application/source & up to 2 animals (valid 6 months)	$500.00
	For additional animals, not to exceed 30 ungulates from the same source property/owner (if no acquisitions to source herd during 6 month period of validity)	$50.00 per animal
	For greater than 30 ungulates from the same source property/owner (if no acquisitions to source herd during 6 months period of validity).	$5.00 per animal

[19.30.9.9 NMAC - Rp, 19.30.9.9 NMAC, 9-29-15]

HISTORY OF 19.30.9 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
Regulation No. 693, Establishing Certain Licenses, Permits, Certificates, And Fees, 4-20-92.
Regulation No. 702, Establishing Certain Licenses, Permits, Certificates, And Fees, 4-23-93.
Order No. 4-92, Amendment No. 1 To Regulation No. 693, Establishing Certain Licenses, Permits, Certificates, And Fees, 6-9-92.
Regulation No. 691, Establishing Financial Liability For Unaccounted For Licenses, 10-3-91.

History of Repealed Material:
19.30.9 NMAC, Game and Fish Licenses/Permits, filed 7-2-2001 - Repealed effective 9-29-2015.

HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.102.500 NMAC, Section 8, effective 10/01/2015.

8.102.500.8 GENERAL REQUIREMENTS:
A. Need determination process: Eligibility for NMW, state funded qualified aliens and EWP cash assistance based on need requires a finding that:
(1) the benefit group's countable gross monthly income does not exceed the gross income limit for the size of the benefit group;
(2) the benefit group's countable net income after all allowable deductions does not equal or exceed the standard of need for the size of the benefit group;
(3) the countable resources owned by and available to the benefit group do not exceed the $1,500 liquid and $2,000 non-liquid resource limits;
(4) the benefit group is eligible for a cash assistance payment after subtracting from the standard of need the benefit group's countable income, and any payment sanctions or recoupments.
B. Gross income limits: The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent (85%) of the federal poverty guidelines for the size of the benefit group.
(1) Income eligibility limits are revised and adjusted each year in October.
(2) The gross income limit for the size of the benefit group is as follows:
(a) one person [~~$827~~] $834
(b) two persons [~~$1,114~~] $1,129
(c) three persons [~~$1,403~~] $1,424
(d) four persons [~~$1,690~~] $1,718
(e) five persons [~~$1,977~~] $2,013
(f) six persons [~~$2,265~~] $2,308
(g) seven persons [~~$2,553~~] $2,602
(h) eight persons [~~$2,840~~] $2,897
(i) add [~~$288~~] $295 for each additional person.
C. Eligibility for support services only: Subject to the availability of state and federal funds, a benefit group that is not receiving cash assistance but has countable gross income that is less than 100% of the federal poverty guidelines applicable to

the size of the benefit group may be eligible to receive services. The gross income guidelines for the size of the benefit group are as follows:

(1) one person [~~$973~~] $981
(2) two persons [~~$1,311~~] $1,328
(3) three persons [~~$1,650~~] $1,675
(4) four persons [~~$1,988~~] $2,021
(5) five persons [~~$2,326~~] $2,368
(6) six persons [~~$2,665~~] $2,715
(7) seven persons [~~$3,003~~] $3,061
(8) eight persons [~~$3,341~~] $3,408
(9) add [~~$339~~] $347 for each additional person.

D. Standard of need:

(1) The standard of need is based on the number of participants included in the benefit group and allows for a financial standard and basic needs.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and the participant's share of benefit group supplies.

(3) The financial standard includes approximately $91 per month for each participant in the benefit group.

(4) The standard of need for the NMW, state funded qualified aliens, and EWP cash assistance benefit group is:

(a) one person $266
(b) two persons $357
(c) three persons $447
(d) four persons $539
(e) five persons $630
(f) six persons $721
(g) seven persons $812
(h) eight persons $922
(i) add $91 for each additional person.

E. Special needs:

(1) Special clothing allowance: A special clothing allowance may be issued to assist in preparing a child for school, subject to the availability of state or federal funds and a specific allocation of the available funds for this allowance.

(a) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age if the child is six years of age or older and less than age 19 by the end of August.

(b) The clothing allowance shall be allowed for each school-age child who is included in the NMW, TBP, state funded qualified aliens, or EWP cash assistance benefit group, subject to the availability of state or federal funds.

(c) The clothing allowance is not allowed in determining eligibility for NMW, TBP, state funded qualified aliens, or EWP cash assistance.

(2) Layette: A one-time layette allowance of $25 is allowed upon the birth of a child who is included in the benefit group. The allowance shall be authorized by no later than the end of the month following the month in which the child is born.

(3) Special circumstance: Dependent upon the availability of funds and in accordance with the federal act, the HSD secretary, may establish a separate, non-recurring, cash assistance program that may waive certain New Mexico Works Act requirements due to a specific situation. This cash assistance program shall not exceed a four month time period, and is not intended to meet recurrent or ongoing needs.

F. Non-inclusion of legal guardian in benefit group: Based on the availability of state and federal funds, the department may limit the eligibility of a benefit group due to the fact that a legal guardian is not included in the benefit group.
[8.102.500.8 NMAC - Rp 8.102.500.8 NMAC, 07/01/2001; A, 10/01/2001; A, 10/01/2002; A, 10/01/2003; A/E, 10/01/2004; A/E, 10/01/2005; A, 7/17/2006; A/E, 10/01/2006; A/E, 10/01/2007; A, 11/15/2007; A, 01/01/2008; A/E, 10/01/2008; A, 08/01/2009; A, 08/14/2009; A/E, 10/01/2009; A, 10/30/2009; A, 01/01/2011; A, 01/01/2011; A, 07/29/2011; A/E, 10/01//2011; A/E, 10/01/2012; A/E, 10/01/2013; A/E, 10/01/2014; A, 10/01/2015]

HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.106.500 NMAC, Section 8, effective 10/01/2015.

8.106.500.8 GA - GENERAL REQUIREMENTS:

A. Limited state funds may result in a suspension or reduction in general assistance benefits without eligibility and need considered.

B. Need determination process: Eligibility for the GA program based on need requires a finding that the:

(1) countable resources owned by and available to the benefit group do not exceed either the $1,500 liquid or $2,000 non-liquid resource limit;

(2) benefit group's countable gross earned and unearned income does not equal or exceed eighty-five percent (85%) of the federal poverty guideline for the size of the benefit group; and

(3) benefit group's countable net income does not equal or exceed the standard of need for the size of the benefit group.

C. **GA payment determination:** The benefit group's cash assistance payment is determined after subtracting from the standard of need the benefit group's countable income and any payment sanctions or recoupments.

D. **Gross income test:** The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent (85%) of the federal poverty guidelines for the size of the benefit group.

(1) Income eligibility limits are revised and adjusted each year in October.

(2) The gross income limit for the size of the benefit group is as follows:

(a) one person [~~$827~~] $834
(b) two persons [~~$1,114~~] $1,129
(c) three persons [~~$1,403~~] $1,424
(d) four persons [~~$1,690~~] $1,718
(e) five persons [~~$1,977~~] $2,013
(f) six persons [~~$2,265~~] $2,308
(g) seven persons [~~$2,553~~] $2,602
(h) eight persons [~~$2,840~~] $2,897
(i) add [~~$288~~] $295 for each additional person.

E. **Standard of need:**

(1) As published monthly by the department, the standard of need is an amount provided to each GA cash assistance benefit group on a monthly basis and is based on availability of state funds, the number of individuals included in the benefit group, number of cases, number of applications processed and approved, application approval rate, number of case closures, IAR caseload number and expenditures, and number of pending applications.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and an individual benefit group member's share of supplies.

(3) **Notice:** The department shall issue prior public notice identifying any change(s) to the standard of need amounts for the next quarter, as discussed at 8.106.630.11 NMAC.

F. **Net income test:** The total countable earned and unearned income of the benefit group after all allowable deductions cannot equal or exceed the standard of need for the size of the GA benefit group. After the countable net income is determined it is rounded down prior to the comparison of the household's income to the standard of need to determine the households monthly benefit amount.

G. **Special clothing allowance for school-age dependent children:** A special clothing allowance may be issued to assist in preparing a child for school, subject to the availability of state or federal funds and a specific allocation of the available funds for this allowance.

(1) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age if the child is six years of age or older and less than age nineteen (19) by the end of August.

(2) The clothing allowance shall be allowed for each school-age child who is included in the GA cash assistance benefit group, subject to the availability of state or federal funds.

(3) The clothing allowance is not counted in determining eligibility for GA cash assistance.

H. **Supplemental issuance:** A one-time supplemental issuance may be distributed to recipients of GA for disabled adults based on the sole discretion of the secretary of the human services department and the availability of state funds.

(1) The one time supplemental issuance may be no more than the standard GA payment made during the month the GA payment was issued.

(2) To be eligible to receive the one time supplement, a GA application must be active and determined eligible no later than the last day of the month in the month the one time supplement is issued.

[8.106.500.8 NMAC - N, 07/01/2004; A/E, 10/01/2004; A/E, 10/01/2005; A, 7/17/2006; A/E, 10/01/2006; A/E, 10/01/2007; A, 01/01/2008; A, 06/16/2008; A/E, 10/01/2008; A, 07/01/2009; A/E, 10/01/2009; A, 10/30/2009; A, 12/01/2009; A, 01/01/2011; A, 07/29/2011; A/E, 10/01/2011; A/E, 10/01/2012; A, 07/01/2013; A/E, 10/01/2013; A/E, 10/01/2014; A, 10/01/2015]

HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.139.500 NMAC, Section 8, effective 10/01/2015.

8.139.500.8 BASIS OF ISSUANCE:

A. **Income standards:** Determination of need in the food stamp program is based on federal guidelines. Participation in the program is limited to households whose income is determined to be a substantial limiting factor in permitting them to obtain a nutritious diet. The net and gross income eligibility standards are based on the federal income poverty levels established in the Community Services Block Grant Act [42 USC 9902(2)].

B. **Gross income standards:** The gross income eligibility standards for the 48 contiguous states, District of Columbia, Guam and the Virgin Islands is 130 percent (130%) of the federal income poverty levels for the 48 states and the District of Columbia. One hundred thirty percent (130%) of the annual income poverty guidelines is divided by 12 to determine monthly gross income standards, rounding the results upward as necessary. For households larger than eight, the increment in the federal income poverty guidelines is multiplied by 130%, divided by 12, and the results rounded upward if necessary.

C. Net income standards: The net income eligibility standards for the 48 contiguous states, District of Columbia, Guam and the Virgin Islands are the federal income poverty levels for the 48 contiguous states and the District of Columbia. The annual income poverty guidelines are divided by 12 to determine monthly net income eligibility standards, (results rounded upward if necessary). For households larger than eight, the increment in the federal income poverty guidelines is divided by 12, and the results rounded upward if necessary.

D. Yearly adjustment: Income eligibility limits are revised each October 1st to reflect the annual adjustment to the federal income poverty guidelines for the 48 contiguous states and the District of Columbia.

E. Issuance table: The issuance table lists applicable income guidelines used to determine [~~food stamp (FS)~~] SNAP eligibility based on household size. Some amounts are increased to meet the needs of certain categorically eligible households. Some of the net income amounts listed are higher than the income limits for some household sizes. Households not categorically eligible for [~~FS~~] SNAP benefits must have income below the appropriate gross income limit for household size.

Household Size	Maximum Gross Monthly Income Categorical Eligibility at 165% of Poverty	Maximum Gross Monthly Income At 130% of Poverty	Maximum Net Monthly Income At 100% of Poverty	Maximum SNAP Monthly Allotment
1	[~~$1,605~~] $1,619	[~~$1,265~~] $1,276	[~~$973~~] $981	$194
2	[~~$2,163~~] $2,191	[~~$1,705~~] $1,726	[~~$1,311~~] $1,328	$357
3	[~~$2,722~~] $2,763	[~~$2,144~~] $2,177	[~~$1,650~~] $1,675	$511
4	[~~$3,280~~] $3,335	[~~$2,584~~] $2,628	[~~$1,988~~] $2,021	$649
5	[~~$3,838~~] $3,907	[~~$3,024~~] $3,078	[~~$2,326~~] $2,368	$771
6	[~~$4,396~~] $4,479	[~~$3,464~~] $3,529	[~~$2,665~~] $2,715	$925
7	[~~$4,955~~] $5,051	[~~$3,904~~] $3,980	[~~$3,003~~] $3,061	$1,022
8	[~~$5,513~~] $5,623	[~~$4,344~~] $4,430	[~~$3,341~~] $3,408	$1,169
$ Each Additional Member	[~~+$559~~] +$572	[~~+$440~~] +$451	[~~+$339~~] +$347	+$146

F. Deductions and standards:

(1) Determination: Expense and standard deduction amounts are determined by federal guidelines and may be adjusted each year. Households eligible based on income and resource guidelines, and other relevant eligibility factors, are allowed certain deductions to determine countable income.

(2) Yearly adjustment: The expense and standard deductions may change each year. If federal guidelines mandate a change, it is effective each October 1st.

(3) Expense deductions and standards table:

Standard Deduction for Household Size of 1 through 3 Standard Deduction for Household of 4 Standard Deduction for Household Size of 5 Standard Deduction for Household Size of 6 or more	$155 [~~$165~~] $168 [~~$193~~] $197 [~~$221~~] $226
Earned Income Deduction (EID)	20%
Dependent Care Deduction	Actual Amount
Heating/Cooling Standard Utility Allowance (HCSUA) Limited Utility Allowance (LUA) Telephone Standard (TS)	[~~$319~~] $318 [~~$116~~] $123 [~~$39~~] $41
Excess Shelter Cost Deduction Limit for Non-Elderly/Non-Disabled Households	[~~$490~~] $504
Homeless Household Shelter Standard	$143
Minimum Allotment for Eligible One and Two-Person Households	$16

[02/1/95, 10/01/95, 02/29/96, 10/01/96, 3/15/97, 01/15/98, 11/15/98, 12/15/99, 01/01/01, 03/01/01; 8.139.500.8 NMAC - Rn, 8 NMAC 3.FSP.501, 05/15/2001; A, 10/01/2001; A, 10/01/2002, A, 09/01/2003; A, 10/01/2003; A/E, 10/01/2004; A/E, 10/01/2005; A/E, 10/01/2006; A/E, 10/01/2007; A/E, 10/01/2008; A/E, 04/01/2009; A/E, 10/01/2009; A, 10/30/2009; A, 04/01/2010; A/E, 10/01/2010; A/E, 10/01/2011; A/E, 10/01/2012; A/E, 10/01/2013; A/E, 10/01/2014; A, 04/16/2015; A, 10/01/2015]

HUMAN SERVICES DEPARTMENT
INCOME SUPPORT DIVISION

This is an amendment to 8.150.100 NMAC, Sections 7, 9, 10, 11 and 12, effective 10/01/2015.

8.150.100.7 DEFINITIONS: [~~RESERVED~~] Unless otherwise apparent from the context, the following definition shall apply throughout these regulations. A life-threatening situation is a related emergency that poses a threat to the health or safety of one or more members of the household.
[8.150.100.7 NMAC – N, 10/01/2015]

8.150.100.9 SPECIFIC AUTHORITIES:

A. Assist eligible households: Section 2602(a) of the Low Income Home Energy Assistance Act states the purpose of LIHEAP is to assist eligible households in meeting the costs of home energy. HSD defines home energy as an energy expense that is incurred primarily for private residential heating or cooling.

B. Outreach: Section 2605(b)(3) of the Administration for Children and Families (ACF) Health and Human Services (HHS) Office of the Community Services (OCS) LIHEAP statute requires the LIHEAP grantee to conduct outreach activities to ensure eligible households, and especially elderly and disabled households, are made aware of the LIHEAP program as well as similar energy-related assistance, utilizing nonprofit agencies as well as the grantee's own field offices in its outreach efforts.

C. Categorical eligibility: No household is categorically eligible to receive LIHEAP. Eligibility is determined during the application process.

D. Financial eligibility: Households must have income at or below 150% of the federal poverty guideline.

[~~D.~~] E. 110% state poverty level: Section 2605(b)(2)(B) of the ACF HHS OCS LIHEAP statute further states that no household may be excluded because of income if it has an income which is less than 110% of the state poverty level.

[~~E.~~] F. Timely issuance of benefits: [~~Section 2605(b)(2)(B) requires the LIHEAP grantee to provide energy assistance benefits in a timely manner.~~] Section 2605(b)(5) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to provide energy assistance benefits in a timely manner as referenced in 8.100.130.11 NMAC.

[~~F.~~] G. Crisis funding: [~~Section 2604 (C) requires the LIHEAP grantee to reserve a reasonable amount of funds for a crisis intervention program.~~] Section 2604 (C)(1) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to reserve a reasonable amount of funds for a crisis intervention program [~~– Section 2604 (C)(1) requires the LIHEAP grantee~~] and to provide assistance to eligible households within 48 hours, excluding weekends and holidays, of the household's application for benefits. [~~This subsection~~] Subsection (2) further requires the LIHEAP grantee to provide assistance within 18 hours, excluding weekends and holidays, to eligible households that apply for benefits in a life-threatening situation.

[~~G.~~] H. Energy need and vulnerable populations: Section 2605 (b)(5) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to take into account the energy needs of low income households, giving priority to those having members of vulnerable populations such as young children, older individuals and individuals with disabilities.

[~~H.~~] I. Owners and renters: Section 2605(b)(8) of the ACF HHS OCS LIHEAP statute requires owners and renters to be treated equitably under the program.

[~~I.~~] J. Tribal LIHEAP: Section 2604(d)(1) of the ACF HHS OCS LIHEAP statute requires that a portion of the grant award be set aside for any Indian tribe in the state requesting an allocation of LIHEAP funds for the purpose of administering its own energy assistance program.

[~~J.~~] K. Administering agency: Section 2605(b)(6) of the ACF HHS OCS LIHEAP statute allows the grantee to designate local administrative agencies to carry out the program and to give special consideration to nonprofit agencies receiving federal funds for other energy-related assistance programs.
[7-1-95, 11-1-95, 11-15-96, 10-01-97, 10-15-98; 8.150.100.9 NMAC - Rn, 8 NMAC 22.LHP.001, 10-1-01; A, 10-1-15]

8.150.100.10 MISSION STATEMENT:

A. **HOUSEHOLD RELATED POLICIES:**

(1) HSD households: Households that receive benefits from programs administered by HSD will be notified of the LIHEAP application period. Those households that wish to apply for LIHEAP benefits may submit an application. It is HSD's policy to issue regular benefits under this program to eligible households that apply for benefits during the specified period of application for regular benefits and that meet the income eligibility requirement and have a responsibility to pay for energy costs as specified in this policy.

(2) Non-HSD households: It is HSD's policy to issue regular benefits under this program to eligible households that receive no other assistance from HSD but that apply for LIHEAP benefits during the specified period of application for regular benefits and that meet the income eligibility requirement and have a responsibility to pay for energy costs as specified in this policy.

(3) Wood-primary heat source: With the exception of households that use wood as their primary heat source and gather their own wood supply, households that do not incur a direct or indirect home energy cost are not eligible.

(4) Renter with energy costs: Renters who meet the eligibility criteria and incur a home energy cost are eligible for benefits under this program.

(5) Homeless applicants who meet the eligibility criteria are eligible for benefits under this program. Applicants who do not incur an energy cost will not be allowed an energy burden as defined in paragraph (1) of subsection A of 8.150.620.9 NMAC.

B. **CRISIS INTERVENTION RELATED POLICIES:**

(1) Crisis verification: Eligible households that have received a written disconnect notice from their utility vendor or a statement of non-delivery or sale of fuel from their fuel vendor due to lack of payment or inability to pay may be eligible to receive a LIHEAP benefit. When a crisis situation is identified, the department is required to provide intervention to resolve the energy crisis. The processing of [~~the applications~~] an application for households in a crisis situation includes [~~contacting the utility company or fuel provider within the specified time frames to resolve the crisis situation~~], a completed application, all necessary verification required to determine eligibility and contacting the vendor to intercede on the household's behalf to resolve the crisis situation. Eligible households with insufficient funds to open an account with a utility vendor or meet the security deposit requirements of a utility vendor may also be eligible to receive a LIHEAP benefit. These households must also be

assisted with crisis intervention. Crisis intervention is not available to households that have received a LIHEAP benefit in the current federal fiscal year.

(2) [~~Crisis timeliness: Assistance to resolve a crisis situation will be provided no later than 48 hours after the household's application for LIHEAP benefits. Eligible households with a life-threatening emergency will be provided assistance no later than 18 hours after the household's application for LIHEAP benefits. Assistance is defined as a contact with the vendor to intercede on the household's behalf to resolve the crisis situation.~~] Crisis situations for eligible households include, but are not limited to, the following scenarios:

(a) a written disconnect notice from utility vendor; or a statement of non-delivery; or sale of fuel from their fuel vendor due to lack of payment, or inability to pay;

(b) have 20% or less bulk fuel; or

(c) have less than a three (3) day supply of firewood.

(3) [~~Utility/vendor mediation: LIHEAP benefit is intended to be a supplement to assist households with their energy bill. The ultimate responsibility for utility payments is the household's. The household will be notified that the LIHEAP benefit alone will not resolve their crisis situation. The household will be informed of other community resources.~~] A life threatening crisis situation for eligible crisis households include but are not limited to the following:

(a) households that contain a child age 1 or younger, or

(b) households that contain elderly age 60 or older, or

(c) households that contain a disabled member,

(d) and contain a household member that their health or wellbeing would likely be endangered if energy assistance is not provided.

(4) Crisis timeliness: Households who apply for LIHEAP benefits and provide documentation that a crisis situation exists will have their application processed in a timely manner.

(a) Assistance to resolve a crisis situation will be provided by the department within 48 hours, excluding weekends and holidays, of the receipt of the completed application for LIHEAP.

(b) Assistance to resolve a life-threatening crisis situation will be provided by the department within 18 hours, excluding weekends and holidays, of the receipt of the completed application for LIHEAP.

(5) Utility/vendor mediation: The LIHEAP benefit is intended to be a supplement to assist households with their energy bill. The ultimate responsibility for utility payments is the household's. The household will be notified that the LIHEAP benefit alone will not resolve their crisis situation. The household will be informed of other community resources.

[7-1-95, 11-1-95, 11-15-96, 10-01-97, 10-15-98, 10-1-00; 8.150.100.10 NMAC - Rn, 8 NMAC 22.LHP.002, 10-1-01; A, 10-1-06; A, 10-1-12; A, 10-1-15]

8.150.100.11 RESPONSIBILITIES AND DELEGATION: The income support division (ISD) of the human services department is responsible for administering the low income home energy assistance program (LIHEAP).

A. State LIHEAP plan: Every year, ISD submits a state plan to the U.S. department of health and human services (DHHS) for New Mexico's administration of LIHEAP. The proposed state plan and the proposed LIHEAP policy manual are made available for public comment and a public hearing is held.

B. LIHEAP administration: ISD is responsible for such matters as:

(1) formulating and interpreting LIHEAP policy;

(2) coordinating with other divisions within HSD for data processing of LIHEAP eligibility and payment;

(3) allocating and distributing LIHEAP monies;

(4) data entry of [~~client~~] applicants/recipients information not available on the department's computer eligibility system; and

(5) oversight responsibility for LIHEAP policy and procedures training and for the review of all LIHEAP training materials.

[8.150.100.11 NMAC - Rn, 8.150.101.9 NMAC & A, 10-1-12; A, 10-1-15]

8.150.100.12 ISD FIELD OFFICE RESPONSIBILITIES: Each of the field offices of the income support division in the state is responsible for:

A. [~~providing outreach and referral for low-income clients, particularly disabled and elderly clients, regarding the LIHEAP program;~~] providing outreach and referrals regarding the LIHEAP program for low income applicants/recipients, particularly disabled and elderly applicants/recipients, crisis applicants/recipients, and households with high home energy burdens;

B. informing low-income households, particularly disabled and elderly [~~clients~~] applicants/recipients, about the eligibility determination process and application procedures for the LIHEAP program;

C. providing documentation to households requesting verification of cash benefits received from the human services department or other documentation available to the department or in the electronic case file;

D. complying with other LIHEAP program directives as may be issued by ISD;

E. assisting all applicant households to complete the LIHEAP application and [~~when necessary interviewing the household when LIHEAP benefits have been requested;~~] resolving questionable information;

F. [~~entering the completed LIHEAP application into the designated LIHEAP computer system;~~] adhere to the deadlines as stated in paragraph (2) of subsection B of 8.150.100.10 NMAC when processing a crisis or life threatening crisis LIHEAP application, making the necessary vendor contact, and documenting the processing times accurately in the case notes;

[~~F.~~] G. entering the completed LIHEAP application into the designated LIHEAP computer system;

[~~G.~~] H. responding to inquiries about the status of a LIHEAP application; and

[~~H.~~] I. [~~processing payment errors when identified; the ISD office must issue a supplement in cases of benefit under-issuances or complete and submit restitution and claim paperwork to the office of the inspector general's restitution services bureau for over-issuances.~~] processing any payment errors when identified regardless of the amount; the ISD office must issue a supplement in cases of benefit under-issuances or complete the necessary actions to establish the claim for the over-issuance and refer to the restitution services bureau for recoupment.

[8.150.100.12 NMAC - Rn, 8.150.102.8 NMAC & A, 10-1-12; A, 10-1-15]

HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.150.110 NMAC, Sections 8, 9 and 10, effective 10/01/2015.

8.150.110.8 RIGHT TO APPLY:

A. [~~Clients/applicants~~] Recipients/applicants: Anyone has the right to apply for any benefits provided by ISD whether or not it appears that he/she will be eligible.

B. Outreach:

(1) HSD responsibilities: HSD conducts outreach regarding the LIHEAP program to eligible households, and particularly elderly and disabled households, through the ISD field offices and all of the offices and suboffices of the state's community action agencies. Additional outreach efforts to elderly and disabled households are made through workshops and conferences held by the state's agency on aging.

(2) Community action agency responsibility: HSD coordinates with the community action agencies to provide information and outreach services regarding LIHEAP and other energy-related assistance programs.

C. Barrier free policy: It is HSD's policy to make the application process for these households as barrier-free as possible. This includes:

(1) paperwork reduction and not requiring reverification by the household of information already available to HSD, such as SSI status;

(2) ease of access to physical locations where application may be made; [~~and~~]

(3) [~~provision of additional assistance for any household or household member who requires it.~~] provide access to the department's online application; and

(4) provide additional assistance for any recipient/applicant who requires it.

D. Annual benefit: Each eligible household will be issued one benefit each federal fiscal year. The benefit may be issued in one or multiple payments depending on the funding availability and the approval of the HSD secretary. Receipt of a LIHEAP benefit from any other LIHEAP administering entity (tribe, state or territory) funded by HHS during any federal fiscal year would prohibit the receipt of LIHEAP in New Mexico during that FFY.

E. [~~Second application period: A second application period may be established under certain conditions at the direction of the HSD secretary. A second application period will be announced in the media. Situations which may justify a second application period include:~~] Supplemental benefit: A supplemental benefit may be established under certain conditions at the direction of the HSD secretary. A supplemental benefit may occur when:

(1) funding levels are predicted to exceed allowable carryover of federal funds to the next federal fiscal year;

(2) emergency weather circumstances.

[7-1-95, 11-1-95, 11-15-96, 10-15-98, 10-1-00; 8.150.110.8 NMAC - Rn, 8 NMAC 22.LHP.111 & A, 10-1-01; A, 01-15-10; A, 10-1-15]

8.150.110.9 SUBMISSION OF FORMS:

A. Applicants: [~~Any household may apply for regular benefits at any one of the income support division county offices located throughout the state during the period specified for application for regular benefits.~~] Any household may apply for benefits during the specified application period:

(1) in person at any local county income support division office;

(2) through the online application; or

(3) submitting an application via mail or fax to any local county income support division office.

B. Application process: In order for a determination of eligibility for regular benefits to be made for these applicant households, the household's [~~application, signed and accompanied by all required supporting documentation, must be received by the income support division county offices by the deadline date of the application period for regular benefits.~~] signed application must be received by the deadline date of the application period of October 1st through September 30th for each federal fiscal year. Required verification must be received by the 30th day after the received date stamped on the LIHEAP application.

C. Application period: [~~The period of application for regular benefits will be year round beginning after the application for the LIHEAP grant has been submitted to the U. S. department of health and human services, and ending August 31. There will be a one month suspension of LIHEAP during the month of September. The opening and closing dates for this application period are advertised in all promotional material regarding the program.~~] The period of application for benefits will be year round beginning after the application for the LIHEAP grant has been submitted to the U.S. department of health and human services, and ending September 30. The application period is October 1st through September 30th for each federal fiscal year.

[~~D. Crisis processing: Households who apply for LIHEAP benefits and provide documentation that a crisis situation exists will have their application processed within 48 hours after submission of an application for LIHEAP benefits or within 18 hours in demonstrated life-threatening situations.~~]

[7-1-95, 11-1-95, 11-15-96, 10-01-97, 12-01-97, 10-1-00; 8.150.110.9 NMAC - Rn, 8 NMAC 22.LHP.112 & A, 10-1-01; A, 10-1-12; A, 10-1-15]

8.150.110.10 DISPOSITION OF APPLICATION/NOTICE:

A. Income support division county office responsibilities: [~~Households who complete the application process for LIHEAP benefits will be provided with a notice of approval or denial. The notice of benefit determination will be provided to applicant no later than 60 days from the date of submission of a completed application. If the household fails to provide the verification required to determine eligibility to ISD, ISD may summarily deny the application after 60 days from the date of the application.~~] Households who complete the application process for LIHEAP benefits will be provided with a notice indicating whether they have been approved or denied. Upon acknowledgement of payment by the vendor, households will be provided with a notice indicating that they have been approved. Upon determination of ineligibility by HSD, households will be provided with a notice indicating that they have been denied. If the household fails to provide the verification required to determine eligibility, ISD may deny the application after 30 days from the date of the application.

B. LIHEAP central office responsibilities: LIHEAP central office staff will complete random reviews of LIHEAP approvals and denials. The review will verify whether LIHEAP policy was correctly applied. If an eligibility error is found or the application is incomplete, a determination will be made to identify any payment errors.

C. Notices: [~~All~~

~~households will be mailed a notice of eligibility for LIHEAP benefits. The notice will list the point total, the benefit amount and the method of issuance.~~] All households will be mailed a notice indicating whether they have been approved or denied for LIHEAP benefits. The notice indicating that an applicant has been approved will list the point calculation, point total, the benefit amount and the method of issuance. The notice indicating that an applicant has been denied will indicate the denial reason.
[7-1-95, 11-1-95, 11-15-96, 11-16-96, 10-15-98, 10-1-00; 8.150.110.10 NMAC - Rn, 8 NMAC 22.LHP.116, 10-1-01; A, 10-1-12; A, 10-1-15]

HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.150.410 NMAC, Sections 9, 11, 12 and 18, effective 10/01/2015.

8.150.410.9 ENERGY RESPONSIBILITY:

A. Energy cost: To be eligible for LIHEAP benefits, the household must incur an energy cost. The energy cost may be for a primary heat source, i.e., the energy source or fuel with which the household is predominantly heated, or for a secondary heat source. A secondary heat source is an energy source that is essential to the process of providing heat to the home. [~~Or, the~~] The energy cost may be for a cooling cost. The cooling cost may be for a primary source, i.e., evaporative cooling or refrigerated air, or secondary cooling. Secondary cooling is the use of energy to operate portable fans, ceiling fans, whole house fans, gable vent fans, or power attic vent fans.

B. Secondary heat source: Electricity to ignite a gas or steam furnace is the most common example of an allowable secondary heat source for LIHEAP purposes. Electricity used only for lighting purposes or to operate fans to distribute heat from a wood-burning stove is not considered an allowable secondary heat source for LIHEAP purposes.

C. Wood-gathering households: Households who use wood as a fuel to heat their home and gather the wood themselves are considered to have a heating responsibility. Regardless of whether a direct or indirect cost was incurred to obtain the wood the household meets this requirement.

D. Direct or indirect utility responsibility: The heating/cooling cost may be direct in the form of a utility payment or fuel purchase, or indirect in the form of a non-subsidized rent payment which either designates or does not designate the included utility cost, or costs associated with obtaining wood for heating households.

E. Crisis intervention: To be eligible for LIHEAP regular or life-threatening crisis intervention, the household must meet the eligibility criteria for regular benefits as specified in 8.150.500.8 NMAC, must not have received a LIHEAP benefit in the current federal fiscal year and, in addition, be able to provide verification that proves the applicant household is facing a current or impending energy crisis, established with any one of the following:

(1) [~~written notice of disconnect for the household from a utility vendor for a disconnect date after the close of the previous LIHEAP crisis season;~~] current notice of disconnect for the household from a utility vendor; or

(2) [~~proof of insufficient funds for the household to open an account with a utility vendor or meet the security deposit requirements of a utility vendor;~~] applicant written or verbal statement of insufficient funds for the household to open an account with a utility vendor or meet the security deposit requirements of a utility vendor; or

(3) statement from the household's fuel vendor that fuel will not be provided without payment.

(4) Life-threatening crisis intervention: The applicant must meet the above criteria for a regular crisis intervention and in addition provide a written or verbal statement advising that the household faces an emergency which poses a threat to the health or safety of one or more members of the household.

F. Community referrals: [~~In circumstances where the household is not eligible for crisis intervention, the household may be informed of other resources in the community, particularly other utility assistance programs available through a community action agency, which may be able to assist the household in meeting its energy expenses.~~] In circumstances where the household is not eligible for crisis intervention, or if a balance remains after the crisis/life threatening intervention has been provided, the household shall be informed of other resources in the community, which may be able to assist the household in meeting its energy expenses.
[7-1-95, 11-1-95, 11-15-96, 10-15-98; 8.150.410.9 NMAC - Rn, 8 NMAC 22.LHP.410, 10-1-01; A, 10-1-12; A, 10-1-15]

8.150.410.11 HOUSING TYPE:

A. Non-subsidized rent: Non-subsidized rent is defined as an obligation to pay for shelter which is entirely the responsibility of the household incurring the expense.

(1) Separate direct costs: Households paying non-subsidized rent who incur a separate heating/cooling cost are eligible for LIHEAP.

(2) Utilities included in rent: Households paying non-subsidized rent whose utility costs are included in their rent, even if no such cost is designated, are eligible for LIHEAP.

B. Subsidized rent: Subsidized rent assistance is defined as a payment for shelter, or shelter and utilities, the cost of which has been reduced due to a subsidy from a housing or other assistance program. University housing does not meet this definition and is therefore not considered subsidized housing.

(1) Separate direct costs: Households receiving subsidized rent assistance who incur a separate direct cost for heating/cooling are eligible for LIHEAP benefits;

(2) Subsidized rent/utilities with additional separate utility cost: Households receiving subsidized rent assistance who receive a subsidy for utilities but who incur an additional out-of-pocket expense for utilities are eligible for LIHEAP;

(3) Subsidized rent with utilities included: Households receiving subsidized rent assistance whose heating/cooling cost is included in their subsidized rent and do not incur an additional out-of-pocket heating or cooling expense are not eligible for LIHEAP;

(4) Subsidized rent with rental cost: Households receiving subsidized rent assistance who pay rent but do not pay utilities are not eligible for LIHEAP; and,

(5) Subsidized rent with no cost: Households receiving subsidized rent assistance who pay no rent and no utilities are not eligible for LIHEAP;

C. Mortgaged or free and clear home: Households who pay a mortgage or own their own home and incur a separate heating/cooling cost are eligible for LIHEAP.

[7-1-95, 11-1-95, 11-15-96, 10-15-98; 8.150.410.11 NMAC - Rn, 8 NMAC 22.LHP.410, 10-1-01; A, 10-1-15]

8.150.410.12 INDIAN TRIBAL ELIGIBILITY: In New Mexico, an Indian tribe may choose to administer its own LIHEAP program for tribal members and request from DHHS an allocation of the state's share of the LIHEAP grant award for this purpose. An Indian tribe is defined as a legal entity of a group of Native Americans living on tribal lands with a distinct and separate government. Residents of tribal land may be eligible for tribal administered LIHEAP or HSD-administered LIHEAP under the following circumstances.

A. Tribes that administer LIHEAP: Indian tribal members living on their tribe's tribal lands, whose tribe administers their own LIHEAP program, are not eligible for HSD-administered LIHEAP benefits.

B. Tribes not administering LIHEAP: Indian tribal members living on the tribal lands of tribes not administering their own LIHEAP program may be considered for HSD-administered LIHEAP benefits providing they meet income eligibility and heating/cooling responsibility requirements as specified in this policy.

C. Indians on other tribes' land: Households that are members of Indian tribes administering their own LIHEAP program but not living on their tribe's tribal lands, may be considered for HSD-administered LIHEAP benefits providing they meet income eligibility and heating responsibility requirements, as specified in this policy, and they did not receive LIHEAP benefits from their tribal government for the current LIHEAP season.

D. Non-Indians and non-tribal members on tribal land: Non-Indians living on tribal lands and Indians living on tribal lands who are excluded from eligibility for LIHEAP by the Indian tribe administering their own LIHEAP program may be considered for HSD-administered LIHEAP benefits providing they meet income eligibility and heating/cooling responsibility requirements as specified in this policy.

E. At the direction of the HSD secretary, HSD may serve tribal members normally excluded due to Subsection A of 8.150.410.12 NMAC if they have not been or do not expect to be served by the tribal LIHEAP program.

[7-1-95, 11-1-95, 11-15-96; 8.150.410.12 NMAC - Rn, 8 NMAC 22.LHP.410 & A, 10-10-01; A, 10-1-05; A, 10-1-06; A, 10-1-12; A, 10-1-15]

8.150.410.18 RECIPIENT RESPONSIBILITIES:

A. Benefit purpose: The household is responsible for using the benefit received for the purpose intended.

B. Erroneously issued benefits: If it is determined the household is not entitled to the benefit received, whether agency or [~~client~~] recipient caused, the household is responsible for paying back the benefits received. The household is responsible for repayment whether the benefit was received directly by the household or paid to a vendor per Subsection H of 8.150.100.12 NMAC, a claim must be established for any erroneous benefit issuance.

[8.150.410.18 NMAC - Rn, 8.150.430.9 NMAC & A, 10-1-12; A, 10-1-15]

HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.150.500 NMAC, Section 8, effective 10/01/2015.

8.150.500.8 NEED DETERMINATION: To be eligible for LIHEAP benefits households must do the following:

A. [~~application: a household member~~] An applicant/recipient or representative must complete an application for LIHEAP benefits and will be interviewed[~~;~~] face to face or telephonically only if information is questionable, to determine crisis or life threatening situations, or if the client has not been interviewed by the department for any other ISD program thirty (30) days prior to the application date stamped on the application. [~~and~~]

B. [~~documentation: the~~] The household must provide proof that they meet the qualifications of the LIHEAP program; current documents used in other public assistance programs may be used for LIHEAP application processes, unless questionable:

(1) proof of identity for the applicant using any of the following documentation:

(a) birth certificates(s); or

(b) baptism certificate; or

(c) hospital or birth record; or

(d) divorce papers; or

(e) alien registration card; or

(f) immigration & naturalization service (INS) records; or

(g) U. S. passport; or

(h) Indian census records; or

(i) family bible; or

(j) school or day care records; or[~~;~~]

(k) government records; or

(l) social security records; or

(m) social service records; or

(n) insurance policy; or

(o) court records; or

(p) church records; or

(q) voter registration card; or

(r) letter from doctor, religious official or school official, or someone else who knows the applicant; or

(s) applicant sworn statement;

(2) proof of citizenship or legal resident status if questionable, such as birth certificate, permanent resident card, naturalization papers, etc.;

(3) social security numbers for all household members[~~;~~] requesting assistance; a social security card is required [~~if the number has not been issued by the social security administration or is being used by another person in the ISD data bases~~] if the department is not able to validate or if the number is questionable;

(4) proof of gross income for all household members, such as check stubs, award letters, statement from employer, etc.;

(5) proof of a utility responsibility with an expense incurred in the past twelve months for the household's current residence:

(a) bill for metered service for a one-month period, or

(b) two (2) consecutive purchase [~~receipt~~] receipts for propane, or a history of the account from the vendor, or

(c) receipt for wood purchase[~~,~~] which includes a statement from the applicant of

the duration of use for said wood, or

(d) rental agreement or landlord statement that utilities are included in rent, or

(e) [~~signed statement or billing history from a utility or fuel vendor;~~] from the utility or fuel vendor, a signed statement or billing history;

(6) account number at current address for the selected heating or cooling expense;

(7) proof of crisis when the situation exists, such as a current disconnect notice, statement of non-delivery of bulk fuel or statement detailing the cost of initiating service;

(8) proof of a life-threatening crisis when the situation exists, such as a current disconnect notice, statement of non-delivery of bulk fuel or statement detailing the cost of initiating service and a written or verbal statement from the applicant advising that the household faces an emergency which poses a threat to the health or safety of one or more members of the household;

[~~(8)~~] (9) proof of disability for at least one household member as determined by another public assistance or federal or state entity; [~~and~~]

[~~(9)~~] (10) proof of emergency expenditures that apply to 8.150.520.18 NMAC; and

[~~(10)~~] (11) proof of the household's main fuel expense for the household's current residence, if applicant/recipient is not requesting LIHEAP for assistance with the main heating or cooling fuel source.

C. eligibility criteria: the household must meet the identity, social security number, income, citizenship, utility responsibility, and residency requirements.

[7-1-95, 11-1-95, 11-15-96, 10-1-97, 10-15-98; 8.150.500.8 NMAC - Rn, 8 NMAC 22.LHP.501.11 & A, 10-1-01; A, 10-1-06; A, 10-1-07; A, 10-1-12; A, 10-1-15]

HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.150.520 NMAC, Part Name & Section 16 effective 10/01/2015.

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 520 [~~EARNED~~] INCOME

8.150.520.16 CRISIS INTERVENTION STANDARDS: Households who are over the income standards but meet the crisis intervention requirements may be eligible for a crisis LIHEAP benefit. If a household is over the income standards, HSD staff should explore the household's financial circumstances and take into account any financial [~~crises~~] crisis in the household that may have resulted in the household's inability to meet its utility or fuel expenses in the past 30 days. In these cases, the household's net income, rather than gross income, may be considered to determine income eligibility for LIHEAP benefits.

[8.150.520.16 NMAC - Rn, 8.150.500.9 NMAC & A, 10-1-12; A, 10-1-15]

HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.150.600 NMAC, Sections 8 and 11, effective 10/01/2015.

8.150.600.8 BENEFITS - ISSUANCE AND USE AND VENDOR RESPONSIBILITIES:

A. Issuance of benefits: [~~Benefits are issued in one of the three following methods:~~] Benefits are issued in one of the following methods:

(1) [~~client warrants: HSD issues benefits directly to clients through client warrants; or~~] recipient warrants: HSD issues benefits directly to recipients through recipient warrants when appropriate and only as a last resort;

(2) vendor payments: HSD issues benefits directly to the vendor; [~~or~~]

(a) [~~HSD will provide the name and, when applicable, customer account number for the LIHEAP-eligible household to the vendor specified by the household; the vendor will notify HSD of mismatches within a specified time frame;~~] HSD will provide the account name and customer account number for the LIHEAP eligible household to the vendor specified by the household; the vendor will notify HSD of mismatches within a specified time frame;

(b) vendors who carry customer accounts will credit eligible households with the amount of the LIHEAP regular benefit no more than 30 days from the time of the payment; vendors who provide fuel on demand will provide fuel to eligible households equal to the amount of the LIHEAP regular benefit no more than 30 days from the date of the eligible household's contact with the vendor to make arrangements for the provision of such fuel;

(c) [~~vendors may transfer excess LIHEAP benefits from the account originally credited to another account they have for the household; the vendor must document the transfer in a manner that meets generally accepted audit standards; in order to transfer LIHEAP funds, the following conditions must be met:~~

~~(i) the vendor must provide multiple utility services or bulk fuel; and~~

~~(ii) a credit remains on the originally credited account after current and delinquent charges are satisfied; and~~

~~(iii) the household approves the transfer; and~~

~~(iv) the utility or bulk fuel account that is credited is used by the household for their heating or cooling needs;~~] vendors shall return to the LIHEAP central office excess LIHEAP benefits from the account originally credited if that account is closed.

(d) vendors should transfer a LIHEAP benefit credit on an account that is closed after the credit is posted; the transfer must be to a new or existing account for the new residence of the recipient household; the vendor must document the transfer in a manner that meets generally accepted audit standards;

(e) vendors may refund LIHEAP benefit credit to a household under certain circumstances when the household moves or will not have service with the company at their residence; the vendor must document the transfer in a manner that meets generally accepted audit standards;

(f) vendors must refund LIHEAP benefit credits on closed accounts to HSD when the credit cannot be transferred to a new account or the household cannot be located.

[~~(3) electronic benefit transfer account: LIHEAP benefits are deposited directly into the household's special account that may be:~~

~~(a) a cash account available to the household at ATMs and retail stores; or~~

~~(b) a special account for LIHEAP payments accessed at authorized utility vendors~~

~~to pay for heating or cooling costs; the EBT card is used at a point of sale (POS) terminal at the utility company office or other retailers authorized to accept utility company payments.~~]

B. Benefit use: [~~The recipient household is responsible for using the benefit for the purpose intended.~~] The recipient household which receives a direct payment is responsible for using the benefit for the purpose intended:

(1) to purchase fuel, such as propane, wood, coal, kerosene, fuel oil or other unregulated fuels;

(2) to pay the household's utility charges, such as those for electric or natural gas services;

(3) to purchase gasoline or tools needed when a household gathers/cuts its own firewood;

(4) to pay a landlord for the utility costs that are included in the rent payment;

(5) to pay for a deposit obligation needed to initiate or continue service.

[7-1-95, 11-1-95, 11-15-96, 10-01-97; 8.150.600.8 NMAC - Rn, 8 NMAC 22.LHP.601 & A, 10-1-01; A, 10-1-05; A, 10-1-06; A, 10-1-12; A, 10-1-15]

8.150.600.11 WINTER MORATORIUM ON UTILITY DISCONNECTION: [~~No utility shall discontinue or disconnect residential utility service for heating from November 15 through March 15 of the subsequent year for certain customers.~~] No utility vendor regulated by the public regulation commission shall discontinue or disconnect residential utility service for heating from November 15 through March 15 of the subsequent year for certain customers.

A. Administering authority: The human services department or a tribal entity that administers its own low income home energy assistance program are designated as the authorities to identify customers who meet the certain qualifications for the winter moratorium. The customer must also meet the New Mexico public regulation commission requirements to receive winter moratorium protection.

B. Qualification: Customers who qualify for the winter moratorium must meet the following income standards:

(1) the customer is a member of a household in which the total gross income is at or below 150% of the current federal poverty guidelines; or

(2) one or more of the household members:

(a) receive supplemental security income; or

(b) are eligible for any federally funded assistance program administered by ISD with income guidelines at or below 150% of the current federal poverty guidelines;

(3) the person in whose name a utility account is listed and the name of the public assistance recipient need not match in order for the customer to be entitled to protection under this section.

C. Proof of qualification:

(1) [~~HSD generated approval notice for certain public assistance programs;~~] HSD generated approval notice for public assistance programs whose income guidelines are at or below 150% of the current federal poverty guidelines;

(2) computer generated notice from HSD; or

(3) form completed by hand from a local ISD office[~~;~~].

[~~(4) HSD generated data file listing qualified households;~~

~~(5) form completed by any agency charged with determining eligibility for a public assistance program; or~~

~~(6) HSD and a utility company/municipality may mutually agree on a method of notification.~~]

[8.150.600.11 NMAC - Rn, 8.150.610.10 NMAC & A, 10-1-12; A, 10-1-15]

HUMAN SERVICES DEPARTMENT

INCOME SUPPORT DIVISION

This is an amendment to 8.150.620 NMAC, Sections 9 and 10, effective 10/01/2015.

8.150.620.9 CALCULATING THE BENEFIT/ASSIGNMENT OF POINTS: To determine the amount of the benefit for households with an energy cost, HSD assigns points for each following factors.

A. Energy costs points: Points are assigned based on the energy burden at the household's current residence for households that have a direct cost for heating or cooling expenses.

(1) Energy burden: Energy burden is "the expenditures of the household for home energy divided by the income of the household." Points are assigned to the household by determining the households' percentage of energy burden. The point allocation for energy burden is:

(a) 0 points for 0 - 5% energy burden;

(b) 1 point for 6 - 10% energy burden;

(c) 2 points for 11 - 15% energy burden; or

(d) 3 points for 16% or more energy burden[~~; or~~].

(2) [~~Energy cost standard: Each year an energy cost standard will be determined. The standard amount will be based on the fuel and electricity standards calculated for the standard utility allowance (SUA) used in the New Mexico food stamp program. The energy cost standard may be used when the monthly utility costs provided by the applicant are less than the standard or the applicant has new service and costs are not available.~~] Additional Energy Burden: If the household's energy burden is for the use of propane, an additional two (2) points will be allocated.

(3) [~~Receipt of energy cost points: Certain households do not receive energy cost points.~~] Receipt of energy burden points: Certain households do not receive energy burden points:

(a) households whose utilities are included in the rent; or

(b) households that use wood to heat their home and do not purchase wood.

(4) Energy standard allowance (ESA): Each year an ESA will be determined. The standard amount will be based on the fuel and electricity standards calculated for the standard utility allowance (SUA) used in the New Mexico supplemental nutrition assistance program (SNAP). The ESA may be used when the monthly utility costs provided by the applicant are: a) less than the standard; or b) the applicant has new service and costs are not available.

B. Income points: HSD assigns income points using the household's monthly total countable gross income and the household size. The number of points is determined by identifying what percentage the household's income is of the federal poverty guidelines (FPG) for the LIHEAP FFY. For example, if the total monthly income is 60% of the FPG, the household will receive three income points. (See below.)

(1) 3 points - income is 0 - 100% of the FPG
(2) 2 points - income is 100 - 150% of the FPG

C. Vulnerable population points: HSD assigns additional points for any household members in the following vulnerable groups.
(1) Age 60 and over: Two (2) points are assigned to eligible households based on the inclusion of one or more household members age 60 or over as determined by birthdate data.
(2) Age 5 and under: Two (2) points are assigned to eligible households based on the inclusion of one or more household members age 5 and under as determined by birthdate data.
(3) Disability: Two (2) points are assigned to eligible households having one or more members with a disability. Disability is defined as physical or mental impairment resulting in substantial reduction in the ability of an individual to care for him/herself or carry out normal activities. When one or more members receive disability based income, the household is entitled to the points. A doctor's statement of current disability will be required for assignment of the point for this factor if the disabled member does not receive disability-based income.
[7-1-95, 11-1-95, 11-15-96, 10-1-97, 12-1-97, 10-1-00; 8.150.620.9 NMAC - Rn, 8 NMAC 22.LHP.621.1 & A, 10-1-01; A, 10-1-05; A, 10-01-06; A, 10-01-07; A, 10-1-15]

8.150.620.10 CALCULATION OF BENEFIT AMOUNT:

A. Prior to the start of the application period projections will be made to determine point value. Anticipated grant of award, potential applicants and the current economy of the state of New Mexico will be used to determine the point value. Households eligible for a LIHEAP benefit will have their point total multiplied times the point value. The product is the amount of payment that is issued to the utility vendor for credit on the household's account or is sent to the household.

B. [~~Benefits are issued for eligible applications received through August 31 or as long as grant of award funds are available, whichever is earlier. The application period ends when funds are exhausted.~~] Based on the availability of funds, benefits are issued for eligible applications received through September 30.

C. At the direction of the HSD secretary, the point value for energy cost points, income points, [~~and/or~~] vulnerable population points, additional energy burden points, or any of their parts, may be adjusted as necessary taking into consideration the factors described in Subsection A of 8.150.620.10 NMAC.
[7-1-95, 11-1-95, 11-15-96, 10-1-97, 10-15-98, 10-1-00; 8.150.620.10 NMAC - Rn, 8 NMAC 22.LHP.621.2, 10-1-01; A, 10-01-05; A, 10-01-06; A, 10-1-15]

HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

The Human Services Department approved, at its 08/17/2015 hearing, to repeal its rule 8.206.400 NMAC, Recipient Requirements (filed 12/02/2013) and replace it with 8.206.400 NMAC, Recipient Requirements, effective 10/01/2015.

HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES
CHAPTER 206 MEDICAID ELIGIBILITY - RECIPIENTS FOR WHOM CYFD HAS FULL OR PARTIAL RESPONSIBILITY
PART 400 RECIPIENT REQUIREMENTS

8.206.400.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.206.400.1 NMAC - Rp, 8.206.400.1 NMAC, 10/1/15]

8.206.400.2 SCOPE: The rule applies to the general public.
[8.206.400.2 NMAC - Rp, 8.206.400.2 NMAC, 10/1/15]

8.206.400.3 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 27-1-12 et seq. NMSA 1978.
[8.206.400.3 NMAC - Rp, 8.206.400.3 NMAC, 10/1/15]

8.206.400.4 DURATION: Permanent.
[8.206.400.4 NMAC - Rp, 8.206.400.4 NMAC, 10/1/15]

8.206.400.5 EFFECTIVE DATE: October 1, 2015, unless a later date is cited at the end of a section.
[8.206.400.5 NMAC - Rp, 8.206.400.5 NMAC, 10/1/15]

8.206.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) medical assistance programs (MAP) eligibility manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAP eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.206.400.6 NMAC - Rp, 8.206.400.6 NMAC, 10/1/15]

8.206.400.7 DEFINITIONS:

A. "Full or partial financial responsibility" means a payment has been made by the children, youth and families department (CYFD) on behalf of the eligible recipient during each month for which MAP eligibility is sought. The nature of CYFD's financial responsibility must be documented. Documentation must include either the court-ordered placement or custody award, and CYFD payments made on behalf of the eligible recipient at the time of application and each subsequent periodic review.

B. "Private institutions" includes accredited and non-accredited residential treatment centers and group homes, and treatment foster care. Institutions specifically excluded from this definition are the youth diagnostic development center, New Mexico boys and girls schools and reintegration centers which are not certified to furnish medical care. A child placed in one of these facilities is not eligible for a MAP category of eligibility.

C. "Substitute care placement" includes placement in a foster home or private institution.
[8.206.400.7 NMAC - Rp, 8.206.400.7 NMAC, 10/1/15]

8.206.400.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.206.400.8 NMAC - Rp, 8.206.8 NMAC, 10/1/15]

8.206.400.9 MAP CATEGORY OF CYFD ELIGIBILITY:

A. MAD is required to furnish coverage to an eligible recipient under 18 years of age for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act)42 CFR Section 436.118).

B. MAD has opted to furnish coverage to an eligible recipient under 18 years of age who meets a MAP category of temporary assistance for needy families (TANF) eligibility requirements except for the definition of "dependent child" for whom CYFD has assumed full or partial financial responsibility (42 CFR Section 436.222).

C. MAD furnishes extended coverage to an eligible recipient over 18 years of age but under 21 years of age who is receiving Chafee independent living assistance.

[8.206.400.9 NMAC - Rp, 8.206.400.9 NMAC, 10/1/15]

8.206.400.10 MAP CATEGORY OF PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) ELIGIBILITY: MAD furnishes extended coverage under the Patient Protection and Affordable Care Act (ACA) to a former foster care recipient up to 26 years of age regardless if he or she also meets a MAP category of other adult eligibility when:

A. the applicant or recipient is a current resident of New Mexico; and

B. the applicant or recipient was in a medical assistance program in New Mexico or any other state at the time he or she turned 18 years of age or aged out of his or her foster care system; and

C. the applicant is not receiving supplemental security income (SSI).

[8.206.400.10 NMAC - N, 10/1/15]

8.206.400.11 BASIS FOR DEFINING THE GROUP: An eligible recipient 18 years of age or under can be eligible for a MAP category of CYFD eligibility if New Mexico bears full or partial responsibility for the eligible recipient and makes a payment on behalf of him or her. An eligible recipient 18 years of age or under will be assigned one of the following MAP categories of eligibility.

A. Category 017: The eligible recipient resides in New Mexico and receives a Title IV-E adoptive subsidy from another state.

B. Category 037: The eligible recipient resides in New Mexico and receives a Title IV-E adoptive subsidy from New Mexico.

C. Category 046: The eligible recipient resides out-of-state and receives a Title IV-E foster care payment from New Mexico. A MAP card is issued by the state in which the eligible recipient resides.

D. Category 047: The eligible recipient currently resides out-of-state and receives a Title IV-E adoption subsidy payment. MAP is issued by the state in which the eligible recipient resides.

E. Category 066: The eligible recipient is in the child protective service component of CYFD and is IV-E eligible or is from a home that meets TANF eligibility requirements.

F. Category 086: The eligible recipient resides in New Mexico, is in the custody of another state and receives Title IV-E foster care payment from that state.

[8.206.400.11 NMAC - Rp, 8.206.400.10 NMAC, 10/1/15]

8.206.400.12 LIVING ARRANGEMENTS: To be eligible for CYFD medicaid, an individual must be under 18 years of age and must be in a substitute care placement or temporarily in a medical facility with an ultimate plan to be placed in substitute care arrangement.

A. Removal from home: An individual who is in the custody of his or her parent or guardian is not eligible for medicaid. When a CYFD medicaid eligible recipient is returned to his or her parent or guardian's custody, CYFD medicaid is terminated.

B. Release from jurisdiction of non-Title XIX facility: An eligible recipient who is released from the jurisdiction and control of the correctional system for whom CYFD has full or partial financial responsibility and is in a substitute care placement can be eligible for CYFD medicaid beginning the first of the month after release from the correctional system if all other eligibility criteria are met.

(1) Permanent release from jurisdiction requirements: An individual living in a correctional facility or under the jurisdiction and control of the correctional system is not eligible for MAD services. This includes an individual temporarily released from a correctional facility for the sole purpose of receiving medical treatment.

(2) Documentation of release: To document that the individual is no longer under the jurisdiction and control of the correctional system, the individual must be permanently released from the correction facility and the court or parole order must specify the following:

(a) the individual is in the custody of CYFD; or

(b) CYFD is required to make monthly payment for the care, maintenance and medical treatment of the individual; in addition, the individual must receive or be evaluated for (or both) the receipt of long-term medical treatment.

C. Independent living arrangements: MAD furnishes extended coverage to an eligible recipient between 18 and 21 years of age who is considered to be in an independent living arrangement if foster care payment is made to the eligible recipient and he or she meets all other MAD eligibility criteria.

[8.206.400.12 NMAC - Rp, 8.206.400.11 NMAC, 10/1/15]

8.206.400.13 ENUMERATION: See 8.200.410 NMAC.

[8.206.400.13 NMAC - Rp, 8.206.400.13 NMAC, 10/1/15]

8.206.400.14 CITIZENSHIP: See 8.200.410 NMAC.

[8.206.400.14 NMAC - Rp, 8.206.400.14 NMAC, 10/1/15]

8.206.400.15 RESIDENCE: See 8.200.410 NMAC.

[8.206.400.15 NMAC - Rp, 8.206.400.15 NMAC, 10/1/15]

8.206.400.16 AGE: To meet the requirements for a MAP category of CYFD eligibility, an applicant or re-determining recipient must be under 18 years of age, except as outlined in Section 9 and 10 of this rule.

A. Students under 19: When an eligible recipient reaches 18 years of age, he or she loses MAP eligibility unless (1) he or she is a full-time student in a secondary school or its equivalent and (2) he or she is expected to complete the program before reaching 19 years of age. In such cases, his or her MAP category of CYFD eligibility is terminated when he or she leaves school or upon his or her 19th birthday, whichever comes first. School attendance must be verified each semester as part of the recipient's MAP re-determination process.

B. Proof of age: The following documents constitute primary

evidence of age:
(1) birth certificate;
(2) adoption papers or records;
(3) hospital or clinic records;
(4) church or baptismal records;
(5) bureau of vital statistics or local government records;
(6) United States passports or immigration and naturalization service's records;
(7) American Indian census reports; or
(8) birth records maintained by the social security administration (SSA).

C. If the age of the applicant or re-determining recipient cannot be established using primary evidence, a minimum of two pieces of corroborating secondary evidence must be used to establish his or her age, such as school records, census records, a court support order not generated by CYFD, his or her physical health practitioner's statement, juvenile court records not generated by CYFD, child welfare records not generated by CYFD, voluntary social services agency records, insurance policies, minister's signed statement, affidavits or military records.
[8.206.400.16 NMAC - Rp, 8.206.400.18 NMAC, 10/1/15]

8.206.400.17 ASSIGNMENT OF MEDICAL SUPPORT: MAD has established requirements of CYFD when the applicant or re-determining recipient meets a MAP category of CYFD eligibility; see 8.200.420 NMAC.

A. CYFD requirements: The authorized representative of CYFD who signs the MAP eligibility application on behalf of the applicant or re-determining recipient must notify MAD of any available third-party medical coverage.

B. CYFD responsibilities for cooperation with HSD child support enforcement division (CSED): CYFD is responsible for cooperating with CSED activities which include:
(1) identifying and locating the absent parent(s) of the eligible recipient receiving MAD services;
(2) establishing paternity of the applicant whose parents were not legally married at the time of his or her birth;
(3) obtaining child and medical support for the applicant or re-determining recipient;
(4) identifying and providing information necessary to pursue third-party health coverage; and
(5) developing procedures for referrals and determination of good cause for not pursuing child support or not requiring cooperation in pursuing such support.
[8.206.400.17 NMAC - Rp, 8.206.400.19 NMAC, 10/1/15]

8.206.400.18 REPORTING REQUIREMENTS: When an applicant or re-determining recipient is approved for a MAP category of CYFD eligibility, the authorized CYFD representative must report within 10 calendar days any known change in the eligible recipient's circumstances which may affect his or her continued eligibility.
[8.206.400.18 NMAC - Rp, 8.206.400.20 NMAC, 10/1/15]

HISTORY OF 8.206.400 NMAC:

History of Repealed Material:
8 NMAC 4.CYM.430 Recipient Rights and Responsibilities, filed 12-30-94 - Repealed effective 7-1-2003.
8.206.400 NMAC, Recipient Policies, filed 6-11-03 - Repealed effective 1-1-2014.
8.206.400 NMAC, Recipient Requirements, filed 12-2-13 - Repealed effective 10-1-2015.

MINING SAFETY BOARD

This is an amendment to 19.6.2 NMAC, Sections 2, 3, 6, through 11, effective 9/29/15.

19.6.2.2 SCOPE: [~~All persons subject to NMSA 1978, Section 69-5-1 et seq and Sections 69-8-1 et seq. and all mines as defined in NMSA 1978, Section 69-8-2.D~~] All persons subject to Section 69-5-1 et seq and Sections 69-8-1 et seq. NMSA 1978 and all mines as defined in Section 69-8-2.D NMSA 1978.
[N, 08/31/06; 19.6.2.2 NMAC - Rn & A, 11.8.2.2 NMAC, 9/30/08; A, 9/29/15]

19.6.2.3 STATUTORY AUTHORITY: [~~NMSA 1978, Section 69-5-1 et seq and Sections 69-8-1 et seq.~~] Section 69-5-1 et seq and Sections 69-8-1 et seq., NMSA 1978.
[N, 08/31/06; 19.6.2.3 NMAC - Rn, 11.8.2.3 NMAC, 9/30/08; A, 9/29/15]

19.6.2.6 OBJECTIVE: The objective of [~~Part 2 of 19.6 NMAC~~] 19.6.2 NMAC is to establish regulations to implement the requirements for emergency notification plans, mine accident emergency operations center and accident notifications as directed in [~~NMSA Chapter 69, Article 5~~] Chapter 69, Article 5 NMSA 1978.
[N, 08/31/06; 19.6.2.6 NMAC - Rn, 11.8.2.6 NMAC, 9/30/08; A, 9/29/15]

19.6.2.7 DEFINITIONS:

A. "Accident" means accident as defined in [~~Title 30 CFR 50.2(h)~~] 69-8-2 A NMSA 1978.

B. "Annual tonnage of coal" means the clean coal tons reported on the form 7000-2 for the previous calendar year.

[~~**B.**~~] **C.** "Board" means the state mining safety board.

[~~**C.**~~] **D.** "CFR" means Code of Federal Regulations.

[~~**D.**~~] **E.** "Days" means calendar days.

[~~**E.**~~] **F.** "Hours worked" means hours reported to mine safety and health administration (MSHA) on the 7000-2 form or for an occupational safety and health administration (OSHA) regulated site on the OSHA form 300-A, for the previous calendar year.

[~~**F.**~~] **G.** "Inspector" means the state mine inspector.

[~~**G.**~~] **H.** "Mine" means mine as defined in [~~Title 30 CFR 50.2(a)~~] 69-8-2 (E) NMSA 1978.

[~~**H.**~~] **I.** "Operator" means operator as defined in in [~~Title 30 CFR 50.2(c)~~] 69-8-2.G NMSA 1978.

[~~**I.**~~] **J.** "Service" means providing any document, paper or pleading to a person either personally or by certified mail, return receipt requested.
[N, 08/31/06; 19.6.2.7 NMAC - Rn, 11.8.2.7 NMAC & A, 9/30/08; A, 1/01/10; A, 10/01/10; A, 9/29/15]

19.6.2.8 REQUIREMENT TO FILE EMERGENCY NOTIFICATION PLAN:

A. All operators of existing mines must prepare an emergency notification plan and submit the plan to the state mine inspector for approval by April 10, 2006. All operators of new or reopened mines shall submit an emergency notification plan to the state mine inspector prior to opening or reopening the mine.

B. Each emergency notification plan must contain procedures for notifying the state mine inspector within thirty (30) minutes of an accident.

C. Any changes made by a mine operator to an approved emergency notification plan shall be submitted by the operator, within no less than seven (7) working days from date of the change, to the state mine inspector for review and approval. The inspector shall no less than annually, from the date of approval of an operator's emergency notification plan, notify the operator to insure that the plan on file with the state mine inspector is current.

D. The inspector shall retain a copy of each mine operator's approved emergency notification plan at the mine accident emergency operations center.

[N, 08/31/06; 19.6.2.8 NMAC - Rn, 11.8.2.8 NMAC & A, 9/30/08; A, 9/29/15]

19.6.2.9 ESTABLISHMENT OF MINE ACCIDENT EMERGENCY OPERATIONS CENTER:

A. The state mine inspector shall establish and maintain the mine accident emergency operations center as the primary state government communications for dealing with mine accidents that:

(1) provides emergency assistance requested by the mine operator or the mine safety and health administration for mine accidents or emergencies; and

(2) is accessible twenty-four (24) hours a day, seven (7) days a week, at a statewide telephone number established and designated by the inspector.

B. Upon receipt of an emergency call regarding an accident, the mine accident emergency operations center shall immediately notify the state mine inspector or his/her designee, who will ensure that the emergency notification plan for the appropriate mine is complied with.

C. In the event of an accident or recovery operation in or about a mine, the state mine inspector may, upon request of the mine operator or the mine safety and health administration, coordinate the assignment of mine rescue teams to assist with needed rescues.

[N, 08/31/06; 19.6.2.9 NMAC - Rn, 11.8.2.9 NMAC, 9/30/08; A, 9/29/15]

19.6.2.10 REQUIREMENTS TO NOTIFY THE MINE ACCIDENT EMERGENCY OPERATIONS CENTER:

A. Whenever an accident occurs in or about a mine or the machinery connected to a mine, the operator of the mine shall give notice within thirty (30) minutes of ascertaining the occurrence of the accident to the mine accident emergency operations center at the statewide telephone number established by the state mine inspector stating the facts and circumstances of the accident and providing the names and telephone numbers of at least two (2) persons [~~located at the site of the accident~~] the operator designates who are knowledgeable [~~in~~] about the accident or about the emergency operations at the mine.

B. Nothing in this section shall be construed to relieve the operator of the mine from any reporting or notification requirement under federal law. Notification of any other federal, state or local agency does not relieve the operator of its obligation to provide notification under Subsection A of 19.6.2.10 NMAC.

[N, 08/31/06; 19.6.2.10 NMAC - Rn, 11.8.2.10 NMAC, 9/30/08; A, 9/29/15]

19.6.2.11 FAILURE TO PROVIDE TIMELY NOTICE:

A. The state mine inspector shall impose a civil penalty of up to one hundred thousand dollars ($100,000) on the operator of a mine if it is determined that the operator failed to give immediate notice as required in 19.6.2.10 NMAC. The inspector may waive imposition of the civil penalty at any time if the inspector finds that the failure to give immediate notice was caused by circumstances outside the control of the operator.

B. In determining the amount of the penalty, the inspector shall consider all relevant factors including whether notice was provided at all to the inspector or, if notice was provided, the lateness of such notice and the seriousness of the accident. The inspector shall utilize the penalty structure approved by the mining safety board.

(1) Penalty points for coal mining operators based on coal production.

Annual tonnage of coal mine failing to provide timely notice	**Penalty points**
0 to 15,000	0
Over 15,000 to 30,000	1
Over 30,000 to 50,000	2
Over 50,000 to 100,000	3
Over 100,000 to 200,000	4
Over 200,000 to 300,000	5
Over 300,000 to 500,000	6
Over 500,000 to 800,000	7
Over 800,000 to 1.1 million	8
Over 1.1 million to 2 million	9
Over 2 million	10

(2) Penalty points for coal mining operators based on the coal production in New Mexico of the controlling [~~enity~~] entity.

Annual [~~coal~~] tonnage of coal produced in New Mexico of controlling entity	**Penalty points**
0 to 100,000	0
Over 100,000 to 700,000	1
Over 700,000 to 1.5 million	2
Over 1.5 million to 5 million	3

Over 5 million to 10 million	4
Over 10 million	5

(3) Penalty points for metal/non-metal operators based on hours worked.

Annual hours worked at a M/NM mine failing to provide timely notice	**Penalty points**
0 to 10,000	0
Over 10,000 to 20,000	1
Over 20,000 to 30,000	2
Over 30,000 to 60,000	3
Over 60,000 to 100,000	4
Over 100,000 to 200,000	5
Over 200,000 to 300,000	6
Over 300,000 to 500,000	7
Over 500,000 to 700,000	8
Over 700,000 to 1 million	9
Over 1 million	10

(4) Penalty points for metal/non-metal operators based on annual hours worked in New Mexico by controlling entity of a M/NM mine.

Annual hours worked in New Mexico by controlling entity of a M/NM mine	**Penalty points**
0 to 60,000	0
Over 60,000 to 400,000	1
Over 400,000 to 900,000	2
Over 900,000 to 3 million	3
Over 3 million to 6 million	4
Over 6 million	5

(5) Penalty points based on operator negligence.

Negligence		
Categories	**Penalty points**	
	Persons endangered	**No endangerment**
Low negligence - The operator failed to report the accident within the required thirty (30) minutes but did report within one (1) hour.	10	5
Moderate negligence - The operator failed to report the accident for more than one (1) hour and less than four (4) hours.	15	7
High negligence - The operator failed to report the accident for more four (4) hours and less than twelve (12) hours.	20	10
Reckless disregard - The operator failed to report the accident for greater than twelve (12) hours, or the operator was previously fined for failure to report an accident within one (1) year of the [~~occurence~~] occurrence.	25	12

(6) Points based on type of accident.

Type of accident (as prescribed in [~~30CFR, Part 50.2 h(1) -(12)~~] 69-8-2 A NMSA 1978 ***There could be more than one (1) category where the penalty points are accrued i.e., a fire at a mine that burns for more than [~~30~~] thirty (30) minutes and results in a fatality, would equal [~~40~~] forty (40) penalty points.***	**Penalty points**	
	Persons endangered	**No endangerment**
Fatality	25	N/A
An injury at a mine that has a reasonable potential to cause death	20	N/A
An entrapment of an individual [~~for more than 30 minutes~~] that has a reasonable potential to cause death	10	[~~5~~] N/A
An unplanned inundation of a mine by a liquid or gas	10	5
An unplanned ignition or explosion of gas or dust	15	5

An unplanned mine fire not extinguished within [~~30 minutes of discovery~~] ten (10) minutes of discovery in an underground mine or thirty (30) minutes at a surface facility of an underground mine	15	7
An unplanned ignition or explosion of blasting agent or explosive	20	10
An unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage.	10	N/A
A coal or rock outburst that causes withdrawal of miners or which disrupts regular mining activity for more than one (1) hour.	15	N/A
An unstable condition at an impoundment, refuse pile, or culm bank which requires emergency action in order to prevent failure, or which causes individuals to evacuate an area; or, failure of an impoundment, refuse pile, or culm bank.	10	N/A
Damage to hoisting equipment in a shaft or slope which endangers an individual [~~or which interferes with use of the equipment for more than thirty minutes~~].	10	[~~5~~] N/A
An event at a mine that causes death or bodily injury to an individual not at the mine at the time the event occurs	20	N/A

(7) Penalty amounts based on total points.

Penalty conversion table	
Penalty points	**Penalty**
0 to 15 points	$5,000
16 to 25 points	$10,000
26 to 35 points	$20,000
36 to 45 points	$50,000
46 to 55 points	$65,000
56 to 65 points	$85,000
66 to 70 points	$95,000
71 or more points	$100,000

C. If the state mine inspector determines that notice was not timely provided, the inspector shall within ninety (90) days after notification of an accident or, if notice was not provided to the inspector, after ascertaining that an accident did occur at a mine, mail a notice of violation with a proposed penalty to the operator.

(1) The operator shall pay the penalty within thirty (30) days after receipt of the notice.

(2) If the operator wishes to challenge the violation or request that the penalty be adjusted or waived, the operator must submit a written petition to the inspector within twenty (20) days after receipt of the notice. Filing of a petition stays the requirement to pay the penalty. The operator may also submit written documentation in support of his petition and may request a meeting with the inspector to discuss the circumstances of the violation.

(3) Within sixty (60) days after receipt of a petition, the inspector shall issue a final order upholding, amending or rescinding the notice of violation and penalty. The inspector may consider actions of the operator in response to the violation when considering amending the penalty. The inspector's final order shall include a statement that the operator may file an appeal of the final order with the board. Unless the inspector's final order is appealed to the board in accordance with Subsection E of [this section] 19.6.2 NMAC, if the final order contains a penalty, the operator shall pay the penalty within thirty (30) days after receipt of the final order.

D. In determining whether to adjust or waive imposition of the penalty, the inspector may consider factors such as, but not limited to:

(1) whether the mine was idled for any reason at the time of the accident;

(2) whether the mine operator encountered communications problems that made it impossible to provide timely notice;

(3) whether medical personnel determined that an injury was not considered life threatening immediately after an accident; if injury becomes life threatening, then notice requirements would be triggered when operator learns of a change in status from a medical authority;

(4) whether a fatality of mine personnel that occurs after an accident is associated with a specific accident;

(5) whether the need to provide emergency medical treatment or emergency rescue and recovery efforts reasonably precluded the mine operator from timely providing notice; and

(6) whether the penalty creates an undue financial hardship on the mine.

E. The operator may appeal the inspector's final order to the board pursuant to these rules.

(1) The operator shall file a written notice of appeal of the inspector's final order within twenty (20) days after service of the final order. Unless a timely written appeal is made, the inspector's final order shall be final and not subject to judicial review. The filing of a timely notice of appeal shall stay enforcement of the inspector's final order until the board issues its written

decision on the appeal.

(2) The operator shall file the written notice of appeal with the chair of the board or the chair's designee, and include the order number and the name of the operator.

(3) If a timely written notice of appeal is made, the board shall consider the appeal at a hearing held no sooner than thirty (30) days and no more than ninety (90) days after receipt of the written notice of appeal. The board shall notify the operator and the inspector of the date, time and place of the hearing at which the appeal will be considered.

(4) No board member with any financial interest affected or potentially affected by the outcome of an adjudicatory hearing may serve as a hearing officer in that hearing or otherwise participate in the hearing. All board members shall adhere with the Governmental Conduct Act.

(5) The board shall review the record compiled before the inspector and shall allow any party to submit arguments at the hearing.

(6) Within twenty (20) days following the hearing the board shall render a written decision affirming, modifying or reversing the inspector's final order, and stating the reasons for that action. This decision shall be signed by the board chair or the chair's designee, and shall be served on both parties within thirty (30) days after the decision is rendered and signed. A person who is adversely affected by a decision of the board pursuant to this section may appeal to the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

[N, 08/31/06; 19.6.2.11 NMAC - Rn, 11.8.2.11 NMAC & A, 9/30/08; A, 1/01/10; A, 10/01/10; A, 9/29/15]

PUBLIC SCHOOLS INSURANCE AUTHORITY

Explanatory paragraph: This is an amendment to 6.50.1 NMAC, Section 9, effective 10/1/2015. In 6.50.1.9 NMAC, Subsection A through M and O through R were not published as there were no changes.

6.50.1.9 BOARD PROCEDURES AND GENERAL AUTHORITY: This section establishes procedures governing the board operations for conducting its business affairs and sets forth the general authority of the board.

***

N. The permanent risk advisory committee and the permanent employee benefits advisory committee shall be chaired by members of the board or if no board member is available, then by staff. The board shall name the advisory committee members from authority participating entities or covered individuals assuring a balance of large and small participating entities and a geographic balance. The board may also name an ex-board member to serve on the advisory committees as a voting member for a term not to exceed three years, with the option to renew the appointment for an additional three years.

***

[6.50.1.9 NMAC - Rp, 6.50.1.9 NMAC, 9/1/2014; A, 10/1/2015]

PUBLIC SCHOOLS INSURANCE AUTHORITY

Explanatory paragraph: This is an amendment to 6.50.10 NMAC, Section 10, effective 10/1/2015. In 6.50.10.10 NMAC, Subsection B through D and F through G not published as there were no changes.

6.50.10.10 REQUIREMENTS FOR ENROLLMENT OF EMPLOYEE DEPENDENTS:

***

A. Eligible employee participants may enroll their eligible dependents during the enrollment period established by the authority. If the employee is enrolled in family medical coverage, a newborn dependent of an employee parent is covered from the date of birth under the same lines of family coverage in which the employee parent is enrolled at the time of the newborn's birth. In cases where the employee is not enrolled in family medical coverage but has family coverage for other lines of employee benefits, the employee parent must enroll the newborn dependent within 31 calendar days from the date of birth to be covered from the date of birth. In cases where there is a change of status in premium (i.e., single to two-party, single to family, or two-party to family) due to the addition of a newborn dependent, the employee parent must enroll the newborn dependent within 31 calendar days from the date of birth to be covered from the date of birth. Certification of information from the official state publicly filed birth certificate or a state-filed birth certificate registration certification must accompany the enrollment form, or if the birth certificate or certification is not available, it must be submitted within [~~31~~] 61 calendar days from the first day of the month following the newborn dependent's date of birth. Adopted dependents of an employee are eligible for coverage from the date of placement by a licensed state agency, a governmental agency or a court of competent jurisdiction. Supportive documentation of such placement is required with the change of status application within [~~31~~] 61 calendar days of the date of placement.

***

E. Proper documentation (together with application for coverage) including evidence of medical insurability where required, must be provided by the person seeking coverage within [~~31~~] 61 calendar days of the qualifying event. Coverage may be rejected where adequate proof and documentation satisfactory to the authority is not submitted in a timely manner.

***

[6.50.10.10 NMAC - Rp, 6.50.10.10 NMAC, 9/1/2014; A, 10/1/2015]

REGULATION AND LICENSING DEPARTMENT
PHYSICAL THERAPY BOARD

This is an amendment to 16.20.10 NMAC, Sections 3, 7 & 8, effective 10-10-2015.

16.20.10.3 STATUTORY AUTHORITY: Section 61-12D-10 NMSA 1978.
[12-15-97; 16.20.10.3 NMAC - Rn, 16 NMAC 20.10.3, 08-31-00; A, 10-10-15]

16.20.10.7 DEFINITIONS:
[~~"Primary health care provider" means a health care professional who is licensed in the U.S. and provides the first level of basic or general health care for individual's health needs, including diagnostic and treatment services, and includes, but is not limited to, a physician (M.D., D.O., D.P.M.), doctor of veterinary medicine (D.V.M.), doctor of chiropractic (D.C.), doctor of dental surgery (D.D.S.), doctor of oriental medicine (D.O.M.), certified nurse practitioner (C.N.P.), certified nurse-midwife (C.N.M.), licensed~~

~~midwife (L.M.), and physician assistant (P.A.) practicing under the auspices of one of the providers listed herein.~~] As used in this section, "licensed health care provider" means: a physician licensed pursuant to the Medical Practice Act; an osteopathic physician licensed pursuant to Chapter 61, Article 10 NMSA 1978; a chiropractic physician licensed pursuant to the Chiropractic Physician Practice Act; a podiatrist licensed pursuant to the Podiatry Act; a dentist licensed pursuant to the Dental Health Care Act; a doctor of oriental medicine licensed pursuant to the Acupuncture and Oriental Medicine Practice Act; a certified nurse practitioner licensed pursuant to the Nursing Practice Act; a certified nurse-midwife licensed pursuant to the Nursing Practice Act and registered with the public health division of the department of health as a certified nurse-midwife; a certified nurse specialist licensed pursuant to the Nursing Practice Act; or a physician assistant licensed pursuant to the Medical Practice Act.
[12-15-97; 16.20.10.7 NMAC - Rn, 16 NMAC 20.10.7, 08-31-00; A, 02-15-04; A, 8-16-10; A, 10-10-15]

16.20.10.8 DIRECT CARE REQUIREMENTS: A physical therapist shall refer a patient to the patient's licensed health care provider if:

A. [~~A physical therapist shall not accept a patient for treatment without an existing medical diagnosis for the specific medical or physical problem made by a licensed primary care provider, except for those children participating in special education programs in accordance with Section 22-13-5 NMSA 1978 and for acute care within the scope of practice of physical therapy. For the purposes of this subsection, "existing medical diagnosis" means substantive signs and symptoms consistent with the episode from a previous primary care provider diagnosis made or confirmed by that provider within the past twelve (12) months.~~

~~**B.** When physical therapy services are commenced under the same diagnosis, such diagnosis and plan of treatment must be communicated to the patient's primary health care provider at intervals of at least once every sixty (60) days, unless otherwise indicated by the primary care provider. Such communication will be deemed complete as noted in the patient's medical record by the physical therapist.~~] After thirty (30) days of initiating physical therapy intervention, the patient has not made measurable or functional improvement with respect to the primary complaints of the patient; provided that the thirty (30)-day limit shall not apply to:

(1) treatment provided for a condition related to a chronic, neuromuscular or developmental condition for a patient previously diagnosed by a licensed health care provider as having a chronic, neuromuscular or developmental condition;

(2) services provided for health promotion, wellness, fitness or maintenance purposes; or

(3) services provided to a patient who is participating in a program pursuant to an individual education plan or individual family service plan under federal law; or

B. At any time, the physical therapist has reason to believe the patient has symptoms or conditions requiring treatment that is beyond the scope of practice of the physical therapist.
[12-15-97; 16.20.10.8 NMAC - Rn, 16 NMAC 20.10.8, 08-31-00; A, 10-10-15]

WORKERS' COMPENSATION ADMINISTRATION

The Workers' Compensation Administration is repealing 11.4.8 NMAC, Workers' Compensation - Individual Self-Insurance (filed 1/3/05) and replacing it with 11.4.8 NMAC, Workers' Compensation - Individual Self-Insurance, effective October 1, 2015.

WORKERS' COMPENSATION ADMINISTRATION

TITLE 11 LABOR AND WORKERS' COMPENSATION
CHAPTER 4 WORKERS' COMPENSATION
PART 8 INDIVIDUAL SELF-INSURANCE

11.4.8.1 ISSUING AGENCY: Workers' Compensation Administration.
[11.4.8.1 NMAC - Rp, 11.4.8.1 NMAC, 10/1/15]

11.4.8.2 SCOPE: This rule applies to all corporations, companies or other entities applying for self-insurance, those who are or were certified for self-insurance, and to their agents and representatives.
[11.4.8.2 NMAC - Rp, 11.4.8.1 NMAC, 10/1/15]

11.4.8.3 STATUTORY AUTHORITY: Chapter 52 NMSA 1978.
[11.4.8.3 NMAC - Rp, 11.4.8.3 NMAC, 10/1/15]

11.4.8.4 DURATION: Permanent.
[11.4.8.4 NMAC - Rp, 11.4.8.4 NMAC, 10/1/15]

11.4.8.5 EFFECTIVE DATE: October 1, 2015, unless a later date is cited at the end of a section.
[11.4.8.5 NMAC - Rp, 11.4.8.5 NMAC, 10/1/15]

11.4.8.6 OBJECTIVE: The purpose of these rules is establish the minimum qualification criteria for a private company or qualifying public entity to apply to the director for permission to self-insure their workers' compensation risk and to establish the criteria to maintain such self-insured status after it is granted by the director.
[11.4.8.6 NMAC - Rp, 11.4.8.6 NMAC, 10/1/15]

11.4.8.7 DEFINITIONS:

A. "Approved excess insurer" means an insurer domiciled within the United States of America or an alien insurer listed in the national association of insurance commissioner's (NAIC) quarterly listing of alien insurers with a rating of "A" or better by A.M. Best or similar rating organization approved by the director.

B. "Approved security" means a letter of credit or surety bond issued by an approved financial institution or surety respectively and used for the payment of claims and related expenses in the event of default by the employer and for reimbursement to the guarantee fund for any benefits paid by the fund on behalf of the employer.

C. "Approved surety" means a financial institution with at least one location in New Mexico or a New Mexico admitted carrier, that is not in the control of the self-insured, and that has a rating of "A" or better from A.M. Best, a rating of "good" or better by Bauer Financial, or similar ratings from organizations approved by the director.

D. "Completed application" means an application for certificate of self-insurance that demonstrates all the eligibility criteria and that attaches all required documentation, as set forth in these rules.

E. "Director" means the director of the workers' compensation administration.

F. "Financially solvent" means an employer's current and continuing ability to pay, as they become due, all existing and future obligations, including workers' compensation benefits to which it is or becomes obligated under the act.

G. "Guarantee fund" means the fund created by Section 52-8-7(A) NMSA 1978 to provide benefits to workers and the families of workers of private individual self-insurers who become insolvent or otherwise unable to meet their financial obligations.

H. "Guarantee board" means the board of directors of the self-insurers' guarantee fund commission.

I. "Parent" means ownership of a subsidiary entity of greater than 50 percent.

J. "Reserves" means the value of claims without regard to expected excess insurance or other recoveries.

K. "Risk management program" means an entity's claims administration personnel, policies and procedures, safety program and personnel, and adequate excess insurance.

L. "Tangible net worth" means net worth less intangible assets.

[11.4.8.7 NMAC - Rp, 11.4.8.7 NMAC, 10/1/15]

11.4.8.8: INDIVIDUAL SELF-INSURANCE:

A. An employer seeking to be certified as a self-insurer under the Act shall make application on a form prescribed by the director.

B. The director shall notify the chairman of the guarantee board of the identity of any applicant for self-insurance within fifteen (15) days of the receipt of the application. The guarantee board shall respond in writing to the director within thirty (30) days of receipt of the notification or be deemed to have expressed no objection to the applicant's membership in the commission. The administration's self-insurance audit staff shall take any written objections into account when making its final recommendation to the director.

C. The director may decline to approve an application for self-insurance if not satisfied that the employer will be able to meet all its obligations under the Act and these rules.

D. Eligibility: Applicants for self-insurance must demonstrate the following base eligibility criteria, each of which must be continuously maintained during the period of self-insurance to maintain eligibility:

(1) a current tangible net worth of at least two million, five hundred thousand dollars ($2,500,000);

(2) the employer has been in business for a period of not less than three (3) years. This requirement may be waived by the director under circumstances where the form of business organization has changed within the three (3) year period but the management and function of the business entity has substantially stayed the same;

(3) a strong trend of financial health and financial solvency;

(4) an acceptable risk management program;

(5) workers' compensation specific excess insurance from an approved excess insurer with retention of $250,000 or less per occurrence and statutory upper limits; an acceptable policy of excess insurance shall provide coverage for all provisions of the act, contain no exclusion of such coverage, and include current New Mexico amendatory endorsement;

(6) an approved security issued in favor of the New Mexico self-insurers' guarantee fund;

(7) a bona fide employment relationship exists between the employer and the employees which it proposes to self-insure; employees who receive wages from or are under the control of any other entity with respect to the day to day supervision and assignment of the work may not come under an individual self-insurance program; employee leasing companies are prohibited from receiving a certificate of self-insurance;

(8) if the employer is a subsidiary, a parental guarantee from the subsidiary's upper-most parent in a form acceptable to the director; a parent company may self-insure its subsidiaries under one certificate in the name of the parent provided the parent meets all eligibility criteria and provides parental guarantees for the subsidiaries and guarantees by each subsidiary for the other(s);

(9) any other reasonable criteria deemed necessary by the director to guarantee payment of workers' compensation claims to injured workers.

E. Application: The employer's application for certificate of self-insurance shall be accompanied by documentation sufficient to demonstrate eligibility, including the following:

(1) a one hundred fifty dollar ($150) non-refundable filing fee made out to the workers' compensation administration;

(2) proof of valid workers' compensation insurance in force for the three years preceding the date of application and continuing in force up to the approved date of self-insurance;

(3) employer's audited financial statements for the most recent fiscal year, presented in accordance with generally accepted accounting principles (GAAP), and financial statements for the preceding two years;

(4) if the employer is a corporation, proof of a resolution adopted by employer's board of directors authorizing and directing the corporation to undertake to self-insure its risks and to comply with the provisions of the act and the rules of the director; a similar official ratification is required from the governing body of any governmental entity;

(5) a detailed accounting of the employer's workers' compensation loss history for the last three (3) years, and experience modifiers for the same period, which shall include all claims covered under a claims "buy-back" program and deductible programs;

(6) an explanation of the safety program, a copy of the safety manual, and resumes of all personnel responsible for the New Mexico safety program;

(7) proof of a proposed policy for workers' compensation excess insurance that complies with the eligibility requirements set forth in this rule, including the declaration page of such policy and all endorsements providing or limiting coverage in New Mexico.

(8) a letter of intent from an approved surety to issue an approved security in an amount and form to be specified by the director, but not less than $200,000; and

(9) proof of compliance with Section 52-1-6.2 NMSA 1978 for the most recent year.

F. Certification.

(1) The director shall act upon a completed application for a certificate of self-insurance within ninety (90) days.

(2) Upon approval, the director shall issue a certificate acknowledging the employer's status as a self-insured under the act; the certificate shall be effective continuously until terminated at the request of the self-insured or revoked by the director.

(3) Upon a merger or other combination by two self-

insured employers, the employers may continue to be self-insured under one certificate provided that the administration is given adequate disclosure, and guarantees and subject to the approval of the director.

(4) The director may issue a provisional certificate, good for not more than one (1) year, to a self-insurer if the director is convinced that any defects are minor in nature and can be corrected within the one (1) year period.

G. Continuing eligibility requirements: Following certification by the director, a self-insured employer shall:

(1) notify the director prior to liquidation, sale, or transfer of ownership and prior to any material change in the employer's financial condition or in New Mexico operations;

(2) obtain the director's approval prior to making any material change in any excess insurance policy or approved security;

(3) notify the director prior to any change in the provider or scope of risk management program;

(4) have at least one (1) claims representative licensed and located within New Mexico to pay workers' compensation claims of claimants residing or located in New Mexico, and to ensure that all adjusters and third party administrators are licensed in New Mexico, regardless of their physical location, and to promptly pay all claims from accounts in financial institutions located within New Mexico;

(5) be subject to sanctions for any act or omission by its agents;

(6) provide proof of coverage for excess insurance policies within 30 days of effective date or renewal and to provide the complete policy within sixty (60) days of effective date or renewal; unauthorized changes appearing in any policy will require immediate remediation by way of reinstatement of approved terms or other measures deemed appropriate by the director;

(7) comply with all conditions required as stated in the employer's self-insurance certificate.

H. Financial responsibility and payment of claims:

(1) The employer shall pay claims for which it becomes obligated in accordance with the act and these rules.

(2) The payment of claims shall continue without regard to the self-insurance status of the employer and without regard to any amount of security posted, whether or not the security is called. An approved security shall be maintained until all claims have expired, subject to determination of the director.

(3) The employer shall maintain a level of reserves at the full undiscounted value of each claim, including indemnity and medical only claims, sufficient to pay all claims and associated expenses.

(4) The employer shall promptly pay guarantee fund assessments, provide documentation supporting assessment calculations, and maintain in good standing membership in the guarantee fund.

(5) The employer shall report loss runs, regardless of type or cost, to the administration in the format prescribed by the director on a semi-annual basis not later than January 31 and July 31 of each year.

(6) Failure to maintain minimum financial criteria and an approved risk management program may result in increased security requirements, termination of self-insurance status, or any other measure deemed necessary by the director for the protection of benefits of injured workers and the guarantee fund.

(7) Upon voluntary or involuntary termination of employer's self-insurance status, the employer shall:

(a) provide any information requested by the director for the purpose of establishing claims liability and financial condition;

(b) comply with any requirement by the director to increase security;

(c) make claims files available to the director for the performance of any audit, examination or review, or for administration of claims in the event of a default;

(d) notify the administration of any changes in address/location, pertinent personnel, claims administration services, location of claims files and related claims personnel, and financial condition; and

(e) promptly notify the director of the employer's current ownership, organizational structure and the employer's ability to pay workers' compensation obligations;

(8) All government entities must have a pre-funded system. All past, present, and future liabilities existing at any time shall be fully accounted for by liquid assets or other assets agreeable to the director. No government entity shall be required to post security.

(9) A self-insurer shall maintain compliance with the requirements of Workers' Compensation Act, WCA rules and the conditions set forth in its certificate of self-insurance.

I. Audits and examinations:

(1) An applicant or self-insured employer is subject to initial or periodic examination or audit by the administration to determine initial or continued eligibility for self-insurance. The applicant or self-insured agrees to bear the costs of any reviews or evaluations and to provide a reasonably private space to conduct the audit and all records required for such audits and examinations.

(2) Audits or examinations under these rules may include, but are not limited to:

(a) audits or reviews of the applicant's or self-insured's records regarding any representation made on its financial statement or application for self-insurance;

(b) audits or reviews of the applicant's or self-insured's records pertaining to its loss history, claims administration, reserves and claimant files;

(c) audits or reviews of safety programs;

(d) interviewing or taking the testimony of the applicant or self-insured, or any of its agents or employees, regarding any matter pertaining to the obligations of the applicant or self-insured under the act or the director's rules; and

(e) audits or examinations the director deems necessary to ensure a self-insured's continued compliance with these rules.

(3) An applicant or self-insured employer shall cooperate fully with administration representatives in any examination or audit and to attempt in good faith to resolve any issues raised in those examinations or audits.

(4) A self-insured employer shall provide its annual audited financial statements to the administration within 90 days of the end of each fiscal year.

J. Denials, revocation and probationary certificates:

(1) The denial,

revocation, or probation of a certificate of self-insurance shall be made by an order signed by the director. Every such order shall state its effective date and shall concisely state what is ordered, the grounds on which the order is based, and the provisions of the act or rules pursuant to which the action is taken.

(2) The director shall deny an application for self-insurance if the employer has failed to demonstrate to the director's satisfaction that the employer meets all requirements of the Act and these rules or has failed to demonstrate its ability to meet all its obligations under the act.

(3) A certificate of self-insurance may be revoked or placed on probationary status if the director, with good cause, ceases to be satisfied that the employer is able to meet all its obligations under the act and these rules. The occurrence of any of the following events shall constitute good cause to revoke or place on probationary status a certificate of self-insurance:

(a) failure of the employer to comply with any provisions or requirements of the act, these rules, or any lawful order or communication of the director;

(b) failure of the approved surety to remain financially solvent, or any other impairment of any aspect of the employer's financial responsibility requirements;

(c) failure to comply with any other statutes, laws, rules, or regulations of the state of New Mexico;

(d) failure to cooperate with the administration to mitigate adverse consequences for injured workers caused by the employer filing for protection under the federal bankruptcy laws;

(e) failure to maintain membership in the New Mexico self-insurers' guarantee fund commission in good standing.

(4) An employer that has been decertified or placed on probation must still comply with the financial responsibilities set forth in these rules and the following additional requirements:

(a) The security amount set after decertification shall account for both known claims and associated expenses, as well as claims incurred but not reported (IBNR) and associated expenses.

(b) If the employer is subject to Section 52-1-6 NMSA 1978, proof of coverage must be provided.

(c) No adjustments to the security will be allowed for three years from the date of the decertification. If after three years, the director has determined that adequate time has passed to reasonably determine the expected long-term liabilities and that there is no risk to benefits of injured workers or the guarantee fund, reduction in security may be approved. At that time, the director may, in his discretion, reduce or return some or all of the security.

(5) Probationary certifications:

(a) A probationary certificate means the temporary revocation of the self-insured's existing self-insurance certificate.

(b) Failure to comply with the Act or these rules may result in the issuance of a probationary certificate of individual self-insurance.

(c) During a probationary period, the employer must comply with all terms specified as conditions of probation within the probationary certificate or in any other lawful order of the director.

(d) The duration of the probationary period shall be within the director's discretion, but shall not extend for a period greater than one year.

(e) The probationary certificate may be withdrawn and the original certificate of self-insurance reinstated, if the self-insured comes into full compliance with the Act, these rules, and all probationary conditions. The reinstatement of the original certificate is subject to the sole discretion of the director.

(f) If the self-insured fails to come into compliance with the Act and the rules by the end of the probationary period, the self-insured's status as a self-insured will be revoked.

K. Recertification:

(1) Any employer formerly certified as a self-insurer who ceases to be certified may not apply for recertification until three (3) years after revocation.

(2) An employer who seeks to reinstate its certificate of self-insurance shall reapply to the director on the form prescribed pursuant to these rules. A non-refundable filing fee of one hundred fifty dollars ($150) must accompany the application for recertification.

(3) If there is a change of ownership whereby the controlling interest of a self-insured changes, the new ownership shall submit a new application to the director for a certificate of self-insurance. A non-refundable filing fee of one hundred fifty dollars ($150) must accompany the new application.

L. Hearings: Any person aggrieved by a decision of the director under these rules may request in writing a hearing before the director. The request shall briefly state the respects in which the party is aggrieved, the relief sought, and the grounds relied upon as the basis of relief.

M. Penalty: In addition to any other sanctions provided herein, failure to comply with any of the provisions of the Act or these rules renders the applicant or self-insured employer subject to penalties as provided in Section 52-1-61 NMSA 1978.

N. Waiver: Any requirement contained in these rules may be waived by specific written authorization of the director. Any interested person may request such a variance or waiver in writing.

[11.4.8.8 NMAC - Rp, 11.4.8.8 NMAC, 10/1/15]

11.4.8.9 SELF-INSURERS' GUARANTEE FUND:

A. Commission membership is composed of all self-insurers as defined in Section 52-8-3(J) NMSA 1978, as a condition of their authority to individually self-insure in the state of New Mexico.

B. Withdrawal of membership:

(1) A member shall be automatically withdrawn from the commission upon the termination of its self-insurance certificate and payment of all assessments due to the date of such termination.

(2) Notwithstanding the termination of membership of a self-insured for whatever reason, that self-insured shall remain liable to the commission for any assessments imposed and based upon insolvencies occurring while the terminated self-insured was a member of the commission.

C. Board of directors:

(1) A board of directors shall be appointed pursuant to Section 52-8-5 NMSA 1978. Every member of the board of directors shall currently be a representative of a commission member in good standing.

The board may adopt by-laws governing the functioning of the commission including the filling of vacancies on the board, removal of board members and conflicts of interest. The board of directors shall elect a chairperson, who shall also be president of the corporation, and a vice-chairman, who shall also be vice president of the corporation. The director shall be the secretary/treasurer of the corporation.

(2) The commission shall maintain such financial records as are necessary to properly reflect assessments, receipts and disbursements (including paid claims) of all funds of the commission. Such records shall also reflect the financial condition of the commission at all times. The commission shall make available its financial records to the administration when so requested.

(3) The commission shall make all necessary records available to an independent auditor to facilitate audits of the commission.

(4) All board members, and such other personnel as may be employed by the board, shall be bonded in an amount determined by the board to be adequate to protect the interests of the commission.

(5) All board members, and such other personnel as may be employed by the board, shall be insured against errors and omissions in an amount determined by the board to be adequate to protect the persons insured and the interests of the commission.

(6) The board may open one or more insured accounts in any number of state or federally chartered financial institutions located in the state of New Mexico, in order to conduct commission business. Reasonable delegation of deposit and withdrawal authority in such accounts may be made, consistent with prudent fiscal policy, but, except as is expressly provided herein, the withdrawal of commission funds shall require the signatures of any two members of the board.

D. Powers and duties of the commission:

(1) The commission, through its board of directors, shall have the power to:

(a) sue and be sued and appear and defend in all actions and proceedings in its corporate name to the same extent as a natural person;

(b) adopt and use a common corporate seal and alter the same; provided, however, that such seal shall always contain the words "not for profit corporation";

(c) elect or appoint such officers and agents as its officers shall require and allow them reasonable compensation;

(d) make contracts and incur liabilities, borrow money at such rates of interest as the corporation may determine, issue its notes, bonds, other obligations and secure any of its obligations by mortgage and pledge of any or all of its property, franchises or income;

(e) purchase, take, receive, lease, take by gift, devise or bequest, or otherwise acquire, own, hold, improve, use or otherwise deal in and with real and personal property, or any interest therein, wherever situated;

(f) have and exercise all powers necessary or convenient to effect any or all of the purposes for which the corporation is organized;

(g) purchase reinsurance or excess insurance as is determined by the board of directors to be necessary to effectuate the purposes and intent of Section 52-8-6(A) NMSA 1978;

(h) review all applicants for membership in the commission and make recommendations to the director concerning the appropriateness of inclusion in, or termination from, membership in the commission with respect to any applicant or member;

(i) provide for imposition of assessments upon members to insure the financial stability of the fund as provided in Section 52-8-6(A) NMSA 1978;

(j) request, upon a majority vote of the board, that the administration determine the condition of any member of the commission which the board in good faith believes may no longer be qualified to be a member of the commission; within thirty (30) days of receipt of such request or for good cause shown, the administration shall make such determination and shall advise the board of its findings; each request for a determination shall be kept on file by the administration and it shall not be open to public inspection pursuant to Section 52-5-21 NMSA 1978.

(2) The commission through its board of directors shall have the following duties:

(a) The commission shall incorporate as a not-for-profit corporation under the laws of New Mexico and shall maintain its corporate status in good standing.

(b) The commission shall be deemed to stand in the place of an insolvent employer to the extent of its obligations on covered claims and, to such extent, shall have all rights, duties and obligations of the insolvent employer as if the employer had not become insolvent.

(c) As to any insolvency proceeding, the commission shall periodically file with the receiver or liquidator of the insolvent member statements of the covered claims paid by the commission and estimates of anticipated claims on the commission. Such filing shall preserve the rights of the commission against the assets of the insolvent member.

(d) To maintain an insolvency fund to meet the obligations of insolvent members, pursuant to Section 52-8-7 NMSA 1978.

(e) At the conclusion of any member insolvency in which the commission was obligated to pay covered claims, prepare a report on the history and cause of such insolvency, based on information available to the commission and submit such report to the administration.

(f) Not later than March 30 each year, submit a financial report for the preceding calendar year in a form approved by the director.

E. Procedure for handling claims:

(1) The commission shall accept for processing all claims against insolvent members which are made by the injured party or their representative.

(2) The commission shall be obligated to pay benefits to injured workers to the same extent as the insolvent member and shall be added as a party in any complaint for benefits or complaints for reduction or termination of benefits filed with respect to the insolvent employer.

(3) The commission may employ persons to process covered claims, giving them reasonable authority to process claims. Any processing of claims in excess of that authority shall be subject to prior approval by the board, or a claims committee established by the board for that purpose.

(4) The commission shall use every reasonable means to expedite the handling of covered claims submitted by the injured worker or representative, and may adopt a protocol

for the handling of those claims.

F. Assessments: Determination and payment of assessment:

(1) Each member shall be given not less than thirty (30) days' notice of the date that an assessment is due and payable.

(2) The assessment notice shall advise the member to remit the assessment payable to the commission. Upon receipt of the assessments, the commission shall deposit said funds in the commission's accounts and shall use them for the purposes stated in the Self-Insurers' Guarantee Fund Act.

(3) The commission shall immediately notify the director if a member fails to pay an assessment when due. The director may penalize the member or revoke its authority to self-insure pursuant to Section 52-1-61 NMSA 1978, and these rules.

(4) The board shall enforce its right to collect any assessment remaining unpaid sixty (60) days after it shall have become due by appropriate action at law or in equity against the non-paying member.

(5) For purposes of calculating assessments, the self-insured may deduct any subrogation recovery in such amounts as are recovered in the same assessment year as they are paid.

(6) If two (2) or more self-insureds combine certificates, the fund balance for the combined entity shall be combined.

(7) Assessments paid by a parent on behalf of a subsidiary which has its own certificate shall be allocated to the subsidiary.

[11.4.8.9 NMAC - Rp, 11.4.8.9 NMAC, 10/1/15]

HISTORY OF 11.4.8 NMAC:
Pre-NMAC History: [RESERVED]

History of Repealed Material:
11 NMAC 4.8.9.5, Establishment of Fund - Repealed effective 10/1/98.
11 NMAC 4.8.9.7.1.A - Repealed effective 10/1/98.
11.4.8 NMAC Individual Self-Insurance, filed 1/3/05 - Repealed effective 10/1/15.

WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.3 NMAC, Section 12, effective 10/1/15.

11.4.3.12 CONDUCT OF PARTIES:

A. Worker's duties:

(1) Worker shall answer reasonable requests from the employer regarding work status.

(2) When a worker is receiving disability benefits, worker shall report to employer, within fifteen (15) days, any return to work, any written medical release to return to work provided to worker, and any physical limitations imposed by a physician and provided to worker in writing.

(3) Worker shall, upon request, give employer the names, addresses, relationship and degree of dependency of all dependents, and may be required to make a verified statement regarding these matters.

(4) Worker may be required to sign the authorization form approved by the WCA to release medical information as a condition of receipt of workers' compensation benefits.

B. Employer's duties:

(1) Upon receipt of a medical release to return to work employer shall notify worker about any required procedures for application for a pre-injury job or modified work.

(2) The employer shall not require the worker to sign any medical release form, other than the WCA approved worker's authorization for use and disclosure of health records, [~~authorization to release medical information,~~] as a condition of receipt of workers' compensation benefits. If a health care provider refuses to accept the WCA approved worker's authorization for use and disclosure of health records, the worker may be required to execute the health care provider's requested release.

(3) The employer shall sign any notice of accident form on the date submitted by the worker.

(4) The employer shall report every accident to their insurer or, in the case of a self-insured employer or member of a self-insurance group, their claims administrator, whether or not the employer considers the claim to be valid, within 72 hours of the earlier of:

(a) actual knowledge of the accident by the employer; or

(b) presentation of a notice of accident form to the employer.

(5) An insured employer is prohibited from making any payment of statutory workers' compensation benefits directly to a worker, the dependents of a worker, or to a service provider on behalf of a worker, except when the employer is a self-insurer, or member of a group self-insurance program, certified by the director. Payments of statutory benefits by a certified self-insurer or a member of a certified group self-insurance program must be made by the authorized claims administrator for the self-insurance program. This prohibition does not preclude any employer from paying a worker his or her full wage or salary pursuant to a wage continuation program, or from paying wages or salary to a worker for limited or light duty employment.

(6) Employers who are subject to the Act but uninsured at the time of a compensable accident shall pay statutory workers' compensation benefits directly to a worker or eligible dependent upon request. Any employer paying a claim under this subsection shall inform the director in writing within 10 days of the initial payment, and shall provide the employer's business location, the total number of employees, and the worker's name, address, and benefit status. The director may impose upon the employer any conditions regarding the manner of payment of benefits as may reasonably be required to protect the interests of the worker and insure compliance with the act.

C. A violation of this section may result in the imposition of criminal, administrative and judicial sanctions.

[5/26/87, 6/20/89, 1/24/91, 6/1/96; 11.4.3.12 NMAC - Rn& A, 11 NMAC 4.3.12, 11/30/04; A, 10/1/15]

WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.4 NMAC, Sections 9, 10, 12 -15 and adding Section 11, effective 10/1/15.

11.4.4.9 FORMS, FILING AND HEARING PROCEDURES:

A. Requirements for filing with the clerk of the administrative court:

(1) All documents to be filed shall be legible, on 8 1/2 x 11 inch white paper, signed in black ink, and shall include a caption with the name of each party and a descriptive title.

(2) For all matters where the filing party requests a hearing, the filing party shall submit self-addressed stamped envelopes for all parties entitled to notice, in addition to request for setting and notice of hearing forms.

(3) A copy of all documents filed with the clerk shall be [~~sent to the opposing party~~] served on all parties of record by the filing party, except as otherwise provided in this rule. If the filing party requests the clerk to serve endorsed copies of a filed pleading, the filing party shall submit sufficient self-addressed stamped envelopes.

B. Computation of time: Any period of time prescribed or allowed by these rules shall be computed pursuant to the method set forth in the rules of civil procedure for the district courts, NMRA Rule 1-006.

C. Name of the insurer:

(1) The workers' compensation complaint, petition for lump sum payment or application to workers' compensation judge must indicate the name of the employer's insurance carrier or claims administrator, if self-insured. If the insurance carrier or claims administrator is not named, the cause shall not be referred for mediation or hearing.

(2) A party or representative may obtain the name of the insurance carrier by mailing or faxing a request to the employer compliance bureau of the WCA. The request must provide the name of the party making the request, date of the accident, and names of the worker and employer. The person requesting information may be required to provide proof of identification.

D. Time for filing of pleadings with the clerk:

(1) Pleadings will be accepted for filing only between 8:00 a.m. and 5:00 p.m., on business days. Pleadings received by fax or other methods of delivery after 5:00 p.m. shall be filed the next regular business day. Complaints submitted by mail shall be deemed filed, for purposes of the act, on the date postmarked.

(2) Faxed pleadings will be filed as the original by the clerk. The clerk may require confirmation of the fax transmission of a pleading. A faxed pleading must comply with requirements established in these rules.

E. Mandatory forms:

(1) Forms designated as mandatory by these rules shall be used when filing a pleading and must be fully and legibly completed by the filing party. Items on the mandatory forms may not be deleted, but additional information may be provided at the end of the text or by additional pages with clear reference to the paragraph being supplemented. The mandatory form may be reproduced or reprinted. [~~Additional information may be provided at the end of the required text or by adding additional pages, with clear reference to the paragraph being supplemented.~~]

(2) The forms listed below have been adopted as mandatory forms. The parties shall use the version of the form available on the WCA website:

(a) workers' compensation complaint;

(b) summons for workers' compensation complaint;

(c) worker's authorization for use and disclosure of health records;

(d) response;

(e) notice of acceptance or rejection of recommended resolution;

(f) notice of disqualification;

(g) application to workers' compensation judge;

(h) summons for application to workers' compensation judge;

(i) subpoena or subpoena duces tecum;

(j) request for setting;

(k) notice of hearing;

(l) HCP disagreement form;

(m) petition for lump sum payment;

(n) summons for petition for lump sum payment;

(o) application to director; and

(p) summons for application to director.

F. Complete filing is required: The complaint shall be filed with a summons, and an executed authorization to release medical information if filed by the worker. The application to workers' compensation judge, application to director, or petition for lump sum payment shall also be filed with a summons, when no service of process has previously occurred in the cause. The clerk may accept an incomplete filing but shall not process the incomplete complaint, application or petition until all required information or documents are submitted. A party must complete the filing within fifteen (15) days of being given notice from the clerk that the filing is incomplete or the clerk's office will issue a notice of administrative closure. The filing party must provide the clerk a copy of a complete filing for each named party at the time of filing.

G. Service of process of initial pleadings:

(1) "Initial pleading" means a complaint, application, or petition for lump sum payment that opens or reopens a case before the administration.

(2) The clerk shall serve the [~~complaint~~] initial pleading to each named party by certified mail, domestic return receipt requested. Service may be accomplished by electronic mail for parties who have registered with the WCA. [~~Service may be deemed complete upon filing. If service is not accomplished by certified mail, the clerk may have service performed by the county sheriff.~~

~~(2) The original pleading shall be filed with the clerk. The filing party must provide the clerk a copy of the complete filing for each named party.~~

~~(3) Application to workers' compensation judge, summons and notice of judge assignment, if applicable, shall be served by the clerk on each named party by certified mail, domestic return receipt requested. Service may be accomplished by electronic mail for parties who have registered with the WCA.~~

~~(4) The filing of a petition for a lump sum payment requires the assignment of a judge, if not previously assigned to the cause. The clerk shall issue a notice of judge assignment, unless waived. The petition and notice of judge assignment shall be served by the clerk upon each party by certified mail, domestic return receipt requested. Service may be accomplished by electronic mail for parties who have registered with the WCA.~~]

(3) In the event service of process by certified mail is unsuccessful, the clerk may attempt service by any means allowable

under the rules of civil procedure for the district courts. If the clerk is unable to accomplish service of the initial pleadings, notice shall be given to the filing party, who shall then be responsible to accomplish service of process.

H. Application to workers' compensation judge:

(1) Unless otherwise provided, all disputes under the act shall be pleaded on a complaint form, which shall be scheduled for mediation under 11.4.4.10 NMAC. A party may file an application to judge only for the following limited forms of relief:

(a) physical examination pursuant to Section 52-1-51 NMSA 1978 (Repl. Pamp. 1991);

(b) independent medical examination pursuant to Section 52-1-51 NMSA 1978 (Repl. Pamp. 1991);

(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); or

(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.

(2) If any claim not enumerated in (1) (a) - (h) above is raised on an application to judge, the application shall be deemed a complaint and processed by the clerk under 11.4.4.9 NMAC and 11.4.4.10 NMAC.

(3) Except for an application seeking relief under Subparagraphs (e), (f) or (g) of Paragraph (1) of Subsection H of 11.4.4.9 NMAC above, an application to judge may not be filed if a complaint has previously been filed in the same cause, and the time period for acceptance or rejection of the recommended resolution has not yet expired. Any other claim for relief arising under Subsection H of 11.4.4.9 NMAC above during that time period shall be raised in the mediation process in accordance with 11.4.4.10 NMAC.

(4) Following the rejection of a recommended resolution, and during the pendency of a complaint, the forms of relief enumerated in Paragraph (1) of Subsection H of 11.4.4.9 above shall be sought through motion.

(5) Written responses to the application, if any, shall be filed within fifteen (15) days of service of an application. A response to application to judge may not raise new claims or issues unless enumerated in Subparagraphs (a) through (h) of Paragraph (1) of Subsection H of 11.4.4.9 NMAC above.

(6) All applications to a judge shall be accompanied by a summons, if applicable, and by a proposed order or a request for setting and notice of hearing. Such hearings as necessary may be scheduled by the assigned judge.

I. Petition for lump sum payment:

(1) All requests for approval of a lump sum shall be pleaded on the WCA mandatory petition form, which shall be signed and verified by the worker or his dependents pursuant to NMRA 1-011(B) or signed by the worker or his dependents before a notary public.

(2) Petitions under Subsection D of Section 52-5-12 shall also be signed by the employer/insurer or their representative or, where applicable, the UEF.

(3) Hearing. For lump sum petitions filed pursuant to Subsection D of Section 52-5-12 NMSA 1978, a lump sum approval hearing shall be held for the purpose of determining 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 petitions, a hearing may be held at the discretion of an assigned workers' compensation judge pursuant to Sections 52-5-12 and 13 NMSA 1978.

(4) Any lump sum 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 hearing.

(5) Written responses to the petition, if any, shall be filed within ten days of service of an petition.

(6) All petitions shall be accompanied by a summons, if one has not previously been issued in the cause, and by a proposed order or a request for setting and notice of hearing. Such hearings will be promptly scheduled by the assigned judge.

[~~**H.**~~] **J.** Subpoenas: Unless otherwise stated herein, the issuance of subpoenas is governed by Supreme Court Rules Annotated 1986, 1-045. The clerk of the WCA may issue a subpoena, signed but otherwise in blank, to a party requesting it, who shall complete it before service. An attorney authorized to practice law in New Mexico and who represents a party before the WCA, as an officer of the court, may also issue and sign a subpoena on behalf of the WCA.

[~~**I.** File shall be segregated upon assignment to judge: Upon rejection of a recommended resolution, the clerk shall segregate the WCA file. The judge shall be provided only those documents file stamped by the clerk. All other documents will be placed in an administrative file by the clerk. The judge shall not have access to the administrative file.~~

~~**J.** Form of orders: Orders authorizing any type of monetary payment for benefits or professional fees, including awards for attorney's fees, shall specify the exact dollar amount and category of benefits awarded.~~]

K. Copies made by clerk: The clerk may provide copies of pleadings or documents in WCA files to parties of record. Copies may be requested by completing a copy request form or by calling the clerk's office. 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.

L. Notice of lien for child support: 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.

M. Communications with WCA employees: WCA employees shall be addressed at all times in a courteous and respectful manner.

N. Appointment of interpreter:

(1) It is the responsibility of the parties to determine if interpretive services are necessary. The employer or the uninsured employers' fund when named and when an employer fails to do so shall be responsible for

arranging for a qualified interpreter for the hearing or mediation conference and shall be responsible for the cost of the interpreter.

(2) An interpreter may be appointed by the judge, director, or mediator. The interpreter shall be a court-certified interpreter, except a non-certified interpreter may serve at mediation conferences.

O. Telephonic conference calls: The employer shall make all necessary arrangements and pay all costs incurred for telephonic conference calls. The director, judge, or mediator may appear telephonically for the conference call.

P. Withdrawal and substitution of counsel:

(1) The entry of appearance of an attorney or a firm for a party in a pending cause shall not be withdrawn without permission of the judge. If no judge has been assigned to the cause, the withdrawal must be approved by the director. A motion requesting withdrawal shall be filed with the clerk and shall indicate whether the client concurs with the motion.

(2) When a party changes counsel, a notice of substitution of counsel shall be filed with the clerk. A copy of the notice shall be mailed to each party. The notice shall contain the new attorney's mailing address, phone and fax numbers.

(3) The attorney of record shall be subject to notice of hearings or other proceedings for [~~six (6) months~~] one year after the entry of the final order or accepted recommended resolution. After the expiration of [~~six (6) months~~] one year from the administrative closing date, the named party shall receive notice of any further proceedings in the cause. The filing party may [~~clerk may require the party filing a pleading to~~] serve a courtesy copy on the prior attorney of record.

Q. Return of records: A party who noticed a deposition may request the return of the original deposition after final disposition of the claim. The clerk may return a deposition 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.

[~~**R.** WCA mandatory forms: The forms adopted by this rule are mandatory and must be fully and legibly completed by the filing party. Items on the mandatory forms may not be deleted, but additional information may be provided at the end of the text or by additional pages with clear reference to the paragraph being supplemented. The format for the forms is provided on the WCA website. The forms listed below have been adopted as mandatory forms:~~

~~(1) workers' compensation complaint;~~

~~(2) summons for workers' compensation complaint;~~

~~(3) authorization to release medical information (HIPAA compliant);~~

~~(4) form letter to health care provider (also referred to as form letter to HCP);~~

~~(5) response;~~

~~(6) notice of acceptance or rejection of recommended resolution;~~

~~(7) notice of disqualification;~~

~~(8) application to workers' compensation judge;~~

~~(9) summons for application to workers' compensation judge;~~

~~(10) subpoena or subpoena duces tecum;~~

~~(11) request for setting;~~

~~(12) notice of hearing;~~

~~(13) HCP disagreement form; and~~

~~(14) petition for lump sum payment.~~]

[~~**S.**~~] **R.** Discovery: Upon the filing of a complaint and by written stipulation of the parties, good cause is presumed and, authorization granted, for the following limited discovery:

(1) the deposition of worker;

(2) the deposition of an employer representative;

(3) the deposition of any authorized health care provider;

(4) the deposition of any provider of an independent medical examination.

[11.4.4.9 NMAC - Rp, 11.4.4.9 NMAC, 10/1/2014; A, 10/1/2015]

11.4.4.10 MEDIATION RULES:

A. Evaluation of complaints:

(1) The director's designee, a mediator, shall evaluate all initial complaints for workers' compensation filed with the administration. Where a new or subsequent complaint is later filed and the matter was previously assigned to a workers' compensation judge, the judge shall determine whether the complaint shall proceed again to mediation or directly to adjudication before the judge.

(2) The director's designee, a mediator, shall evaluate the merits of [~~every~~] the complaint for workers' compensation, including, but not limited to, jurisdiction, proper parties, compensability, extent of any benefits due the worker, and the strength or availability of any defenses. The mediator may also evaluate the compliance of the parties with the mediation rules.

B. Mandatory production:

(1) No later than five (5) days before the mediation the parties shall exchange any and all of the following within the parties' possession:

(a) medical records, including unpaid bills;

(b) payroll records;

(c) witness statements; and

(d) any other documents related to a claim or defense.

(2) The documents outlined above do not need to be produced if they are unrelated to a claim or defense, have previously been produced or there is a good faith objection or privilege.

(3) The purpose of mandatory production is to [~~insure~~] ensure the parties and the mediator have access to all pertinent information regarding the issues disputed in the complaint.

(4) The mandatory production shall be provided to the mediator by delivering it to the clerk of the court. Documents attached to a complaint or response to a complaint which are listed in the mandatory production subsection shall be treated as mandatory production. Mandatory production delivered to the clerk of the court shall not be part of the case record, although parties may file a notice indicating compliance with the rule, and shall be destroyed by the WCA following issuance of the recommended resolution.

C. Mediation conferences:

(1) Notice of the mediation conference shall be mailed by certified mail, domestic return receipt requested, to the parties, accompanied by a copy of the complaint, summons and authorization to release medical

information, at least ten (10) days before the mediation conference. Service may also be accomplished by electronic mail for parties who have registered with the WCA. Mediation conferences reset through the WCA electronic portal will result in notification via electronic mail to registered users.

(2) Responses:

(a) The respondent shall file a timely response not less than five (5) days prior to the mediation conference.

(b) The response shall include a short summary of reasons for denials of any benefits claimed, statements of facts and affirmative defenses.

(c) An answer, as set forth in Subsection [~~D of 11.4.4.12~~] B of 11.4.4.13 NMAC, may be filed in lieu of this response.

(3) Rescheduling and continuances: By agreement, the parties may reschedule a mediation to occur within 90 days of filing the complaint. Mediation conferences reset through the WCA electronic portal will result in notification via electronic mail to registered users.

(4) Mediation conference: The mediation conference shall be held at the workers' compensation administration building in Albuquerque, unless otherwise requested by the parties and agreed to by the assigned mediator. Parties to the conference who live outside of the Albuquerque area may appear via video conference equipment at one of the administration's regional offices. Mediation conferences may also be conducted telephonically with prior approval from the mediator.

(5) Amendments of caption/joinder of parties: 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.

(6) The purposes of mediation conferences and duties of mediator are:

(a) to bring the parties together and, with the use of mediation and other dispute resolution techniques, attempt to settle disputed issues by discussing the facts and applicable law pertaining to the complaint and by suggesting compromises or settlements;

(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 sixty (60) days of the filing of the complaint;

(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 for administrative investigation, if appropriate.

(7) Conduct of mediation conferences:

(a) The conduct of the mediation conference shall be in the control of the mediator.

(b) The mediator shall be addressed in a courteous and respectful manner by all parties.

(c) 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.

(d) Employer and attorney, or a representative, if no attorney has entered an appearance, and worker and attorney, if any, shall appear in person at the mediation conference. The mediator may enter recommendations against any party failing, without excuse as determined by the mediator, to attend the conference.

(e) 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.

(f) This rule does not prohibit the appearance of an employer through an adjuster or third-party administrator, nor prohibit a worker from attending a mediation conference with an unpaid lay assistant.

(g) The attendance of any other person at the mediation conference is subject to the discretion of the mediator.

(h) 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.

(i) The parties are encouraged to prepare written narratives and summaries to assist the mediator.

D. Recommended resolutions:

(1) The mediator shall issue the recommended resolution within sixty (60) days of the filing of the complaint unless the parties have stipulated to a waiver of the sixty (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 mediator shall serve a copy of the recommended resolution on the parties by certified mail, domestic return receipt requested, unless the parties have registered with the agency to receive notice by electronic service. [~~and thereby waived their statutory right to service by certified mail.~~]

(3) Receipt by the WCA of a certified mail domestic return receipt with a signature and date of receipt shall create a presumption of receipt by the party of the recommended resolution on the indicated date. Service by electronic mail will create a presumption of receipt upon transmission.

(4) Receipt by the WCA of a certified mail domestic return receipt with a signature, but without a date of receipt, shall create a rebuttable presumption of receipt of the recommended resolution on the fourth day following transmission of the recommended resolution by the WCA.

(5) [~~Effect of recommended resolution.~~] Parties shall timely file, within thirty (30) days of receipt of the recommended resolution, a notice of acceptance or rejection of recommended resolution. [~~Failure to timely accept or reject the recommended resolution shall conclusively bind the parties to the recommended resolution. The thirty (30) day period begins on the date of receipt of the recommended resolution and ends on the date of actual receipt, by the clerk, of the notice of acceptance or rejection of recommended resolution. For purposes of this rule, mailing does not constitute actual receipt and no additional time shall be granted or allotted for mailed responses to the recommended resolution.~~] Mailed responses must be received by the clerk of the court on or before the thirtieth (30th)

day after receipt of the recommended resolution. No additional time is allowed for mailing. Receipt by the clerk of a facsimile of notice of acceptance or rejection of recommended resolution shall constitute actual receipt.

(6) Effect of recommended resolution:

[~~(b)~~ (a) A rejection in whole or in part of a recommended resolution shall result in assignment to a judge for a new determination of all issues in a formal hearing.

[~~(c)~~] (b) A rejection shall contain a statement of the party's reasons for rejecting the recommended resolution.

[~~(d)~~] (c) The judge shall have access to the recommended resolution.

[~~(e)~~] (d) [~~Effect of acceptance or rejection:~~] 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 [~~motion~~] application and proposed order to the director, reciting good cause, within thirty (30) days following receipt by that party of the recommended resolution. The clerk may cancel any judge assignment when a rejection is withdrawn.

(e) 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 within sixty (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 by the enforcement bureau.

(3) Failure to comply with the mediation rules, including those requiring mandatory production of evidence prior to the mediation conference, or to cooperate with an inquiry of the enforcement bureau may subject a party to penalties pursuant to Sections 52-1-28.1, 52-1-54 and 52-1-61, NMSA 1978 (Repl. Pamp. 1991), and in accordance with 11.4.5 NMAC.

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 shall not be expanded or modified in any way by the issuance of an amended recommended resolution.

G. Confidentiality: Notes of the mediator taken in conducting a mediation conference are not subject to discovery and shall not be admissible as evidence in any legal proceeding.

[11.4.4.10 NMAC - Rp, 11.4.4.10 NMAC, 10/1/2014; A, 10/1/2015]

11.4.4.11 DIRECTOR'S MATTERS:

A. The following matters shall be pleaded on the application to director form:

(1) judge assignment disputes;

(2) requests for relief from an untimely rejection of a recommended resolution;

(3) requests 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 assignment of nurse case management 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 workers' compensation judge to resolve applications brought pursuant to Section 52-5-11 NMSA 1978 when other matters are pending before the workers' compensation judge.

(2) Designation of recipient.

(a) An application to the director, request for setting, and notice of hearing shall be filed with the clerk of the court with self-addressed stamped envelopes for all parties entitled to notice. The application shall also be accompanied by a summons, if one has not previously been issued in this cause.

(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 a 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 sixteen (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.

(b) 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.

(c) The director may suspend, in whole or in part, benefit payments 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, 10/1/2014; 11.4.4.10 NMAC - N, 10/1/2015]

[~~11.4.4.11~~] 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 (Repl. Pamp. 1991). The peremptory right to disqualify a judge allowed by Subsection D of Section 52-5-5 NMSA 1978 (Repl. Pamp. 1991), 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 (Repl. Pamp. 1991).

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 sixty (60) day effective period allowed in Subsection B of Section 52-1-49 NMSA 1978 (Repl. Pamp. 1991), is not enlarged by the HCP's referral.

D. Notice of change of HCP:

(1) The sixty (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 fifty (50) days of the initial sixty (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 ten (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 (3) 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 eleven (11) days after issuance of the notice of change.

(2) An objection can be filed after the three (3) 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 [~~11.4.7.13~~] Section 11 of 11.4.7 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 (7) 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 sixty (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 (7) 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 - Rn & A, 11.4.4.11 NMAC, 10/1/2015]

[~~11.4.4.12~~] 11.4.4.13 THE FORMAL HEARING PROCESS:

[~~**A.** Application to judge:~~

~~(1) Unless otherwise provided, all disputes under the act shall be pleaded on a complaint form, which shall be scheduled for mediation under 11.4.4.10 NMAC. A party may file an application to judge only for the following limited forms of relief:~~

~~(a) physical examination pursuant to Section 52-1-51 NMSA 1978 (Repl. Pamp. 1991);~~

~~(b) independent medical examination pursuant to Section 52-1-51 NMSA 1978 (Repl. Pamp. 1991);~~

~~(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); or~~

~~(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.~~

~~(2) If any claim not enumerated in (1) (a) - (h) above is raised on an application to judge, the application shall be deemed a complaint and processed by the clerk under 11.4.4.9 NMAC and 11.4.4.10 NMAC.~~

~~(3) Except for an application seeking relief under Subparagraphs (e), (f) or (g) of Paragraph (1) of Subsection A of 11.4.4.12 NMAC above, an application to judge may not be filed if a complaint has previously been filed in the same cause, and the time period for acceptance or rejection of the recommended resolution has not yet expired. Any other claim for relief arising under Subsection A of 11.4.4.12 NMAC above during that time period shall be raised in the mediation process in accordance with 11.4.4.10 NMAC.~~

~~(4) Unless the relief sought is stipulated by both parties, the responding party shall file a response to application to judge within ten days of receipt of an application. A response to application to judge may not raise new claims or issues unless enumerated in Subparagraphs (a) through (h) of Paragraph (1) of Subsection A of 11.4.4.12 NMAC above.~~

~~(5) All applications to a judge shall be accompanied by a proposed order or a request for setting, as appropriate, and by self-addressed stamped envelopes for all parties entitled to notice. Such hearings as necessary may be scheduled by the assigned judge.~~

~~**B.** Approval of petition for lump sum:~~

~~(1) All requests for approval of a lump sum shall be plead on the WCA mandatory petition form, which shall be signed and verified by the worker or his dependents pursuant to NMRA 1-011(B) or signed by the worker or his dependents before a notary public.~~

~~(2) Petitions under Subsection D of Section 52-5-12 shall also be signed by the employer/insurer or their representative or, where applicable, the UEF.~~

~~(3) Hearing. The lump sum hearing shall be for the purpose of determining that the agreement is voluntary, that the worker understands the terms, conditions and consequences of the settlement agreement or any release, under Subsection D of Section 52-5-12 NMSA 1978, and that the settlement is fair, equitable and provides substantial justice to the parties.~~

~~(4) Any lump sum petition filed pursuant to this rule shall comply with Section 52-1-54 NMSA 1978 and counsel for the parties may concurrently file a petition for approval or award of attorney fees, if appropriate, to be heard in the context of the lump sum hearing.~~

~~(5) All petitions shall be accompanied by a summons, when a summons has not already issued in the case. All other petitions shall be accompanied by a request for setting and self-addressed, stamped envelopes for all parties entitled to notice. Such hearings will be promptly scheduled by the assigned judge.~~

~~**C.**~~**]** **A.** Assignment of judge:

(1) Upon receipt of a timely rejection of a recommended resolution[~~, or~~] an application to judge, or petition for lump sum payment, the clerk shall assign a judge to the cause and shall notify all parties of the judge assignment by certified mail, domestic return receipt requested. This notice shall be considered the initial notice of judge assignment.

(2) Each party shall have the right to disqualify a judge. To exercise the peremptory right to disqualify a judge, a party must file a notice of disqualification of judge no later than ten (10) days from the date of filing of the notice of assignment of judge. The clerk shall assign a new judge to the cause and notify all parties by certified mail, domestic return receipt requested. A party who has not exercised the right of disqualification may do so no later than ten (10) days from the filing of the notice of reassignment of judge.

(3) No action may be taken by any judge on a cause 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 [~~stipulated~~] waiver of the right to disqualify a judge [~~or a waiver of the ten (10) day period in which to disqualify a judge~~]. Such waiver shall forever bar the parties' right to disqualify a judge in that cause.

(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.

[~~D.~~] B. Commencement of adjudication process and answer to complaint: 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 twenty (20) days of date of filing of the initial notice of assignment of judge unless already filed in lieu of the response required under Paragraph (2) of Subsection C of 11.4.4.10 NMAC. The answer shall admit or deny each claim asserted in the complaint. Any affirmative defenses to the complaint shall be stated in the answer. The answer shall comply with the general rules of pleading set forth in the rules of civil procedure for the district courts of New Mexico.

[~~E.~~] C. The assigned 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 claim.

[~~F.~~] D. Medical evidence:

(1) Live medical testimony shall not be permitted, except by an order of the judge.

(2) A form letter to HCP, completed by an authorized HCP, may be admitted into evidence. The employer shall pay the costs for completion of the form letter.

[~~G.~~] E. Depositions:

(1) The parties should make a good faith effort to obtain a completed and signed form letter to HCP prior to setting the deposition of the HCP.

(2) Depositions shall be taken pursuant to Supreme Court Rules Annotated 1986, 1-030. Reasonable notice shall be deemed to be not less than five (5) days prior to the date set for the deposition.

(3) The original deposition shall be kept by the party who noticed the deposition.

(4) Deposition testimony of authorized HCPs shall be admissible, in lieu of live testimony.

(5) The use of depositions shall otherwise be governed by Supreme Court Rules Annotated 1986, 1-032. A party intending to use a deposition shall notify the other party of the intended use at least ten (10) days prior to trial. Any objection to the use of the deposition shall be determined at the adjudication hearing.

[~~H.~~] F. Written discovery procedures: If authorized, interrogatories, request for production or inspection, and requests for admissions shall be governed by Supreme Court Rules Annotated 1986, 1-033, 1-034 and 1-036.

[~~I.~~] G. Motions: All motions, except in open court, shall be written and comply with Supreme Court Rules Annotated 1986, 1-007.1. Motions for summary judgment shall comply with Supreme Court Rules Annotated 1986, 1-056.

[~~J.~~] H. Settlement/pre-trial conferences: The judge shall have discretion to schedule settlement conferences or pre-trial conferences to expedite adjudication. A settlement conference with the assigned judge shall require the consent of all parties either on the record or in writing.

[~~K.~~] I. Continuance of hearing:

(1) The continuance of an adjudication hearing shall be at the discretion of the judge for good cause shown.

(2) All discovery, disclosure and exchange deadlines shall be extended by the granting of a continuance unless otherwise ordered.

[~~L.~~] J. Hearings:

(1) Failure to appear at a hearing after proper notice and without good cause may result in the imposition of sanctions.

(2) The parties shall appear personally at the adjudication hearing, without the necessity of a subpoena. Unless excused by a judge, the parties shall appear personally or through their legal representatives at all other hearings properly noticed.

(3) All hearings shall be recorded by audio tape recording or by any other method approved by the director.

(4) 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.

(5) Under exceptional circumstances and in the interest of justice, within ten (10) days of the close of the adjudication hearing, the judge has discretion to direct or allow supplementation of evidence.

[~~M.~~] K. Additional rules: Unless otherwise stated or necessarily implied in the preceding rules, the rules of evidence and the rules of civil procedure for the district courts of New Mexico shall apply to and govern proceedings within the adjudication process.

[11.4.4.13 NMAC - Rn & A, 11.4.4.12 NMAC, 10/1/2015]

[~~11.4.4.13~~] 11.4.4.14 APPROVAL OF ATTORNEY'S FEES:

A. The award of attorney's fees may be requested on an 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 claim has been settled or adjudged. For purposes of the Workers' Compensation 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 claims 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.

[11.4.4.14 NMAC - Rn & A, 11.4.4.13 NMAC, 10/1/2015]

[~~11.4.4.14~~] 11.4.4.15 SANCTIONS:

A. The judge may sanction any party, attorney, or representative thereof, 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 enforcement bureau under 11.4.5 NMAC for further investigation, administrative prosecution and imposition of penalties.

[11.4.4.15 NMAC - Rn & A, 11.4.4.14 NMAC, 10/1/2015]

[~~11.4.4.15~~] 11.4.4.16 COURT AUTHORIZED RELEASE OF MEDICAL RECORDS: Any party or any authorized health care provider (HCP) may file a petition for court authorization to release medical records. Such petitions 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.

A. The assigned workers' compensation judge (judge) shall decide medical record disputes. If no judge has been assigned, a judge shall be appointed by the clerk upon the filing of a petition for court authorization to release medical records for the resolution of that matter only.

B. The judge appointed by the clerk is not assigned pursuant to Subsection C of Section 52-5-5 NMSA 1978 (1990). The peremptory right to disqualify a judge allowed by Subsection D of Section 52-5-5 NMSA 1978 (1993) does not apply. No party or authorized HCP may disqualify a judge appointed to hear a petition for court authorization to release medical records.

C. 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 a finding of materiality by a preponderance of evidence.

D. If a petition for court authorization to release medical records is filed with the clerk, the judge shall hear the petition within seven (7) days from the filing of the petition. The judge may issue a minute order at the conclusion of the hearing on the petition. If the judge does not issue a minute order, the judge shall issue an order not later than three (3) days after the conclusion of the hearing. A minute or formal order resolving the petition shall have the force of law with respect to the parties and to the authorized HCP.

E. If, after a judge has ordered the release of records pursuant to this rule, an HCP fails to provide records to a payer, the party which is to receive the records shall give the HCP (1) written notice of the obligation to produce the records and (2) an endorsed copy of the judge's order or minute order. If the records are not produced within five (5) days of the actual delivery of the notice, the payer's obligation to timely pay shall be tolled until the actual production of the records.

F. If any judge involved in the adjudication of the claim finds that the withholding of records of health information after an order to produce has obstructed the efficient administration or adjudication of a claim, then:

(1) Notice shall be given to the authorized HCP who has withheld records that have been ordered disclosed and a hearing shall be scheduled to determine if the withholding of records was unreasonable.

(2) If the judge finds after notice to the HCP and an opportunity to be heard that the continued withholding of records by the HCP is unreasonable, the director may find the HCP in violation of this rule and penalize pursuant to Section 52-1-61 NMSA 1978 (1990).

[11.4.4.16 NMAC - Rn & A, 11.4.4.15 NMAC, 10/1/2015]

WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.7 NMAC, Sections 7-15, effective 10/1/15.

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. "Cannabis Program" means the state of New Mexico department of health medical cannabis program.

[~~B.~~] C. "Caregiver" means any provider of health care services not defined and specified in NMSA 1978, Section 52-4-1.

[~~C.~~] D. "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.

[~~D.~~] E. "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.

[~~E.~~] F. "*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 annual 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®), copyright 2012 by the American medical association (AMA). CPT is developed by the 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.

[~~F.~~] G. "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".

H. "Department of health (DOH)" means the state of New Mexico department of health.

[~~G.~~] I. "Director" means director of the workers' compensation administration (WCA) or designee.

[~~H.~~] J. "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.

[~~I.~~] K. "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.

[~~J.~~] L. "Freestanding ambulatory surgical center (FASC)" means a separate facility that is licensed by the New Mexico department of health as an ambulatory surgical center.

[~~K.~~] M. "Health care provider (HCP)" means any person, entity, or facility authorized to furnish health care to an injured or disabled worker pursuant to NMSA 1978, Section 52-4-1, including any provider designated pursuant to NMSA 1978, Section 52-1-49, 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 NMSA 1978, Section 52-4-1(P).

[~~L.~~] N. "Hospital" means any place currently licensed as a hospital by the department of health pursuant to NMSA 1978, Section 52-4-1(A), 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.

[~~M.~~] O. "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 (6) weeks.

[~~N.~~] P. "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 NMSA 1978, Section 52-1-51.

Q. "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.

R. "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.

[~~O.~~] S. "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 NMSA 1978, Section 52-1-51(C).

[~~P.~~] T. "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.

[~~Q.~~] U. "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.

[~~R.~~] V. "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).

[~~S.~~] W. "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.

[~~T.~~] X. "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.

[~~U.~~] Y. "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.

[~~V.~~] Z. "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 annual order or has not otherwise been designated by these rules.

[~~W.~~] AA. "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.

[~~X.~~] BB. "Utilization review" means the evaluation of the necessity, appropriateness, efficiency, and quality of health care services provided to an injured or disabled worker.

[~~Y.~~] CC. "Worker" means an injured or disabled employee.

[11.4.7.7 NMAC - Rp, 11.4.7.7 NMAC, 12-31-13; A, 10-1-15]

[CPT only copyright 2014 American Medical Association. All rights reserved.]

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 workers' compensation administration (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 health care provider fee schedule for any health care service as set forth in these rules.

(4) These rules and the director's annual order adopting the health care provider fee schedule utilize the edition of the c*urrent procedural terminology* referenced in the director's annual 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 annual 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 (5) business days of receipt of all supporting documentation and no later than five (5) 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) If an authorization or 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 shall document all attempts to obtain authorization from the date of the initial request.

(4) 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.

(5) 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).

C. Billing provision ground rules.

(1) Billing shall be made in accordance with billing instructions issued by the director in conjunction with the annual fee 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 thirty (30) calendar days from the end of the month in which services were rendered. Initial billing of inpatient services shall be issued no later than sixty (60) calendar days from the date of discharge.

(6) Failure of the provider to submit the initial billing within the time limits provided by these rules shall constitute a violation of these rules but does not absolve the employer of financial responsibility for the bill.

(7) 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 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 (10) 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.

(8) 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.

(9) 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.

(10) 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.

(11) 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.

(12) No charge shall be made to any party to the claim for the initial copy of required information.

(13) The patient/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.

(14) 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.

(15) For any reimbursement under the fee schedule or these rules that is based upon provider's cost, the provider shall submit a copy of the invoice showing that cost either at the time of billing or upon the payer's request.

(16) [~~Effective July 1, 2015, the payer shall be capable of receiving bills electronically and of submitting electronic payment pursuant to a system generally recognized and used in the medical community.~~

~~(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 ten (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 patient/worker with a valid workers' compensation claim, payer is responsible for timely good faith payment within thirty (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) 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 pursuant to NMSA 1978, Section 52-1-49(A); 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 who subcontracts bill review services remains fully responsible for compliance with these rules.

(6) Fees and payments for all physician professional services, regardless of where those services are provided, are reimbursed within the health care provider 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 WCA billing instructions 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.

[11.4.7.8 NMAC - Rp, 11.4.7.8 NMAC, 12-31-13; A, 10-1-15]

[CPT only copyright 2014 American Medical Association. All rights reserved.]

11.4.7.9 FEES FOR HEALTH CARE SERVICES:

A. Health care provider fee schedule.

(1) The director shall issue an order pursuant to NMSA 1978, Section 52-4-5 not less than once per annum setting the health care provider 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 fee schedule, the order shall contain a brief description of the technique used for derivation of the fee schedule and a reasonable identification of the data upon which the fee schedule was based.

(3) The health care provider fee schedule is procedure-specific and provider-neutral. Any code listed in the edition of the *current procedural terminology* adopted in the director's annual 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 fee schedule shall be released to the public not less than thirty (30) days prior to the date upon which it is adopted and public comments will be accepted during the thirty (30) days immediately following release.

(5) After consideration of the public comments the director shall issue a final order adopting a fee schedule, which shall state the date upon which it is effective. The final fee schedule order shall be available at the WCA clerk's office not less than twenty (20) days prior to its effective date.

B. Hospital ratio.

(1) All hospitals shall be reimbursed at the hospital ratio set forth in the health care provider fee schedule. A new hospital shall be assigned a ratio of 67%.

(2) The assigned ratio is applied toward all charges for compensable services provided during a hospital inpatient stay and emergency department visit.

(3) The ratio does not apply to procedures that are performed in support of surgery, even if performed on the same day and at the same surgical site as the surgery.

(4) By February 1 of each calendar year, all hospitals shall provide to the WCA the most recent full year filing of their HCFA/CMS 2552 G-2 worksheet prepared on behalf of the organization. A hospital may specifically designate this worksheet as proprietary and confidential. Any worksheet specifically designated as proprietary and confidential in good faith shall be deemed confidential pursuant to NMSA 1978, Section 52-5-21 and the rules promulgated pursuant to that provision. Failure to comply may result in fines and penalties.

(5) Appeal of assigned ratio by hospitals. A written appeal may be filed with the director within thirty (30) days of the assignment of the ratio. The director will review the appeal and respond with a written determination. The director may require the hospital to provide additional information prior to a determination and in his discretion may conduct a hearing. The director's written determination shall be issued within thirty (30) days of the final submission of all information regarding the appeal to the director. The director's written determination shall be final.

C. 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 health care provider fee schedule.

(2) Pharmacies shall not dispense more than a thirty (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 [~~prepared by pharmacists~~] shall be paid [~~on a by-report (BR) basis~~] in accordance with the fee schedule.

(5) Any medications dispensed and administered in excess of a twenty four (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 ten (10) day supply for new prescriptions only. The payment for health care provider dispensed medications shall not exceed the cost of a generic equivalent.

D. 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 health care provider 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 fee schedule;

(d) reimbursement shall be limited to the quantity set forth in the 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.

E. Referrals.

(1) If a referral is made within the initial sixty (60) day care period as identified by NMSA 1978, Section 52-1-49(B), 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.

[~~E.~~] F. 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.

[~~F.~~] G. 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 using CPT code 90899 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, 12-31-13; A, 10-1-15]

[CPT only copyright 2014 American Medical Association. All rights reserved.]

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 [~~a written motion~~] an application to the director and proposed order, supported by an original affidavit of the HCP seeking approval[~~, on forms acceptable to the director~~]. 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 NMSA 1978, Section 52-4-1, 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.

[11.4.7.10 NMAC - Rp, 11.4.7.9 NMAC, 12-31-13; A, 10-1-15]

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 thirty (30) calendar days of the documented receipt date of the payer's disposition, [~~or~~] 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 issued to both parties along with a copy of the request for director's determination.

D. Both parties shall have fifteen (15) days from the date of the notice of receipt of request for director's determination to present to the director and opposing party any pertinent additional documentation.

E. The director or his designee 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 forty-five (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.

F. 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 thirty (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.

G. 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.

H. Any time frame set forth in 11.4.7.11 NMAC may be waived by the director, in writing, for good cause shown.

I. 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, 11.4.7.13 NMAC, 12-31-13; A, 10-1-15]

11.4.7.12 INPATIENT ADMISSIONS/ CASE MANAGEMENT/PEER 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) All employers, insurers, and third party administrators are required to communicate and provide information to the contractor for the purpose of facilitating the provision of services. The employer, insurer or third party administrator shall be required to 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 patient/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 WCA or its contractor, if any, shall provide to the worker's employer, legal representative, insurer, or third party administrator a copy of written reports upon written request.

B. Inpatient admission review.

(1) For every inpatient admission the following information shall be provided to the WCA or its contractor at least forty eight (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.

(4) Any practitioner or hospital discharge planner ordering or arranging a transfer of a worker to another facility shall report to the WCA at least twenty four (24) hours prior to any transfer all of the information in required by Paragraph (1) of Subsection B of 11.4.7.12 NMAC.

(5) Throughout the period of time in which inpatient services are being provided, the WCA shall monitor the worker's treatment regime, including treatments, procedures, and length of stay.

(6) If a hospital or practitioner reports that an employer's insurance carrier or third party administrator has not authorized the admission, the WCA shall issue a recommendation concerning the medical necessity and appropriateness of the admission service and the assigned length of stay before the close of the next business day after the report is submitted to the WCA.

C. Case management and peer review

(1) Any party may refer a case to the WCA, for case management or peer review. The WCA in its sole discretion will assign cases to its contractor for case management or peer review, as provided by the contract in effect.

(2) Upon assignment of a case by the WCA for case management, the contractor shall notify the worker, his/her legal representative, employer, insurer, or third party administrator of the selection.

(3) The contractor shall have the right to contact the worker, insurer, third party administrator, legal representative, and all practitioners involved in the case.

(4) The contractor shall give reasonable notice and an opportunity to the worker or his or her representative to be present during all contacts by a case manager with the insurer, third party administrator, legal representative(s), and practitioners.

(5) Any party who objects to the WCA referring a case for case management shall notify the WCA of its objection by filing an application to the director not later than thirty (30) days of receiving notice of the assignment from the contractor or the medical cost containment bureau.

[11.4.7.12 NMAC - Rp, 11.4.7.14 NMAC, 12-31-13; A, 10-1-15]

11.4.7.13 NON-CLINICAL SERVICES:

A. A practitioner may charge up to one dollar ($1.00) per page for the first ten (10) pages and up to twenty cents ($0.20) for each page thereafter for copying medical records and reports, except as provided in Paragraphs (10), (11), (12) and (13) 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 up to forty five dollars ($45.00) for completion of the form letter to health care provider.~~] A practitioner may charge for the completion of the form letter to health care provider the amount set forth in the fee schedule.

C. Depositions.

(1) An HCP may not charge more than four hundred dollars ($400) for the first hour or any portion thereof; and not more than three hundred sixty dollars per hour ($360/hour) for the second and subsequent hours, prorated in five (5) minute increments. An HCP may not charge more than two hundred dollars ($200) for the first hour of deposition preparation time actually spent, and not more than one hundred and twenty dollars ($120) per hour for the second or third hours, prorated in five (5) minute increments, up to a maximum of three (3) 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 [~~or preparation time~~]. 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 four hundred dollars ($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 forty eight (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 four hundred dollars ($400.00) for the first hour and three hundred sixty dollars ($360.00) for each subsequent hour is permitted. Fees for the second and subsequent hours shall be prorated in five (5) minute increments. An HCP may not charge more than two hundred dollars ($200) for the first hour of deposition preparation time actually spent, and not more than one hundred and twenty dollars ($120) per hour for the second or third hours, prorated in five (5) minute increments, up to a maximum of three (3) hours."

D. 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.

[~~(1) Travel and lodging expenses shall be limited by order of the judge.~~

~~(2) No fee for preparation time may be charged or collected.~~

~~E. The party paying for medical treatment shall pay the fees set forth in this rule. Ultimate responsibility for payment for copies of medical records and reports shall be determined pursuant to 11.4.4 NMAC pertaining to discovery costs.~~

~~F. When a dispute arises regarding compliance with this non-clinical fee schedule any party, or the judge, may request a hearing to determine compliance with this rule.~~

~~(1) If a hearing to determine compliance is requested, or on the judge's own motion, the judge shall enter an order confirming or denying compliance with this rule.~~

~~(2) The judge's order may assess costs, expenses, and attorney fees against a non-complying party or practitioner.~~]

E. Disputes concerning the non-clinical 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, 11.4.7.15 NMAC, 12-31-13; A, 10-1-15]

11.4.7.14 ENFORCEMENT: Any complaint of a violation of these rules shall be made, in writing, to the [~~WCA director through~~] the medical cost containment bureau, enforcement bureau, or assigned workers' compensation judge, if any.

[11.4.7.14 NMAC - Rp, 11.4.7.16 NMAC, 12-31-13; A, 10-1-15]

11.4.7.15 DATA ACQUISITION:

A. The insurer must report an inpatient hospital bill to the WCA within ten (10) to ninety (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. [~~In any event, the insurer must report the inpatient bill no later than the ninety second (92nd) day from the date of payment.~~]

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 or his designee and seek penalties pursuant to NMSA 1978, Section 52-1-61.

[11.4.7.15 NMAC - Rp, 11.4.7.17 NMAC, 12-31-13; A, 10-1-15]

WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.9 NMAC, Section 8, effective 10/1/15.

11.4.9.8 GROUP SELF INSURANCE:

A. Application and maintenance:

(1) All the requirements for application and maintenance of a certificate of group self-insurance are contained in NMSA 1978, Section 52-6-5. In addition, the following shall apply:

(a) Submit with the application a non-refundable filing fee of five hundred dollars ($500.00).

(b) The application shall [~~contain~~] include the group's pro forma financial statement, following generally accepted accounting principles, presented in a format acceptable to the director.

(c) If a surety bond is posted to satisfy the security requirements of the act, the surety bond shall be written by an insurance company rated "A" or better by A.M. Best or similar rating service approved by the director written by a New Mexico admitted surety.

(d) If a financial security endorsement is posted to satisfy the security requirements of the act, the instrument shall be written by a financial institution with locations in New Mexico rated "good" or better by Bauer Financial or similar rating service approved by the director.

(e) Specific excess insurance shall be written with statutory upper limits. The insurance shall be written by an [~~acceptably~~] insurance company rated [~~company approved and regulated by the New Mexico department of insurance to write excess insurance in the state of New Mexico, or a company that is otherwise approved by the director.~~] "A" or better by A.M. Best or similar rating service approved by the director, domiciled within the United States of America or an alien insurer listed in the national association of insurance commissioner's (NAIC) quarterly listing of alien insurers, the policy must include the current New Mexico amendatory endorsement.

[~~(d) The required fidelity bond for the administrator shall be written at a minimum of two hundred fifty thousand dollars ($250,000).~~

~~(e)~~] (f) The required fidelity bond for the service company providing claims service shall be written at a minimum of two hundred fifty thousand dollars ($250,000) and issued by a New Mexico admitted carrier.

[~~(f)~~] (g) A performance bond issued by a New Mexico admitted carrier of two hundred fifty thousand dollars ($250,000) shall be provided for the service company providing claims service, if requested by the director.

[~~(g)~~] (h) A fidelity bond for any member of the board of trustees of the group having signatory authority with respect to the group's funds or investments, or as a condition precedent to any board of trustees action creating or changing such signatory authority, is required and shall be written at a minimum of two hundred fifty thousand dollars ($250,000) and issued by a New Mexico admitted carrier.

(i) The required fidelity bond for the administrator shall be written at a minimum of two hundred fifty thousand dollars ($250,000) and issued by a New Mexico admitted carrier.

[~~(h)~~] (j) A statement of the type of business in which employers in the proposed group are engaged and an explanation of how they meet the criteria of "same or similar" contained in NMSA 1978, Section 52-6-2(B).

[~~(i)~~] (k) An actuarial report/study based on at least 3 years loss history of the group's proposed members, including loss projections for the group.

(2) After considering the group's application and all supportive documentation, the director shall act upon a completed application for a certificate of approval within sixty (60) business days. If, because of the number of applications pending, the director is unable to act upon an application within

that period, the director shall have an additional sixty (60) days to act.

(3) The definitions in Subsections A and B of 11.4.9.7 NMAC shall be applied prospectively only, commencing with the effective date of this rule. Existing members of a group which would be ineligible for membership under this rule shall not be excluded from membership in the group on the basis of this rule. In the event that a member's coverage is not reinstated within thirty days of the delivery to the director of the notice of cancellation or termination required in NMSA 1978, Section 52-6-9 (B), the former member will be considered a new applicant for purposes of qualifying as a member of the group.

(4) Each group will screen applicants to their group based upon the definition of "same or similar type of business" contained in this rule. No group shall admit any prospective member that is not in the same or similar type of business.

(a) Each group will designate in writing for the director, a general category from the standard industrial classification manual, designated as a lettered division heading, which most closely fits the type of businesses represented by the sponsoring trade or professional association.

(b) The director will presume that businesses properly included in that division are in the same or similar type of business as are other businesses in the group.

(c) A group may request in writing that additional two digit major group codes, three digit industry group codes or four digit industry codes from the standard industrial classification manual, other than those under the group's designated lettered division heading, be approved.

(i) The request for designation of a business as a same or similar type of business for a group shall be accompanied by a written explanation which must satisfy the director that the businesses are significantly related to the sponsoring trade association's industry.

(ii) The director may consult widely accepted publications which classify types of businesses for the purpose of considering the approval or disapproval of such requested designations.

(d) Upon prior written approval by the director, a group may add to its roster an individual business which is not otherwise clearly eligible for membership. A request for approval of such individual business shall be accompanied by a written explanation demonstrating to the satisfaction of the director that the business, because of its particular circumstances should be deemed to be in the same or similar type of business as the other members of the group.

(e) The director shall approve or disapprove such requests in writing.

(f) The WCA will follow its established protocol to ensure prompt response to requests for such designations.

(5) [~~Each group will certify to the director on each report of~~] By submitting the roster of additions [~~submitted,~~] the group certifies that any additions to the group's roster are in the same or similar type of business as the other members of the group.

(6) Groups may offer claims "buy back" programs to their members provided: a written narrative describing the program shall be provided to the participants and the WCA; and, details of claims bought back must be provided to the participating member, or its designee, or to the WCA upon request.

B. Evaluation factors: The director shall decline to approve an application for group self-insurance upon a finding that the proposed group does not meet all the requirements of the Group Self-Insurance Act and the rules thereunder. In determining whether a group can meet the requirements of the Group Self-Insurance Act (NMSA 1978, Sections 52-6-1through 52-6-25) and the rules thereunder, the factors to be considered by the director shall include, but not be limited to, the following:

(1) organizational structure and management background;

(2) compliance with NMSA 1978, Section 52-6-2(B);

(3) services provided by the group;

(4) statistical reporting and expertise;

(5) workers' compensation loss history and risk;

(6) source and reliability of financial information;

(7) sufficiency of premium;

(8) proposed bylaws, underwriting guidelines, membership application, and membership agreement;

(9) the distribution of group members as to size, premium and loss exposure;

(10) adequacy of reserve methodology;

(11) proposed excess insurance coverage;

(12) adequacy and form of security;

(13) claims administration personnel, policies and procedures;

(14) safety program;

(15) financial condition of proposed members;

(16) results of financial evaluation of the group.

C. Financial responsibility:

(1) The group shall submit audited financial statements on an annual basis within one hundred and eighty (180) days of its fiscal year end.

(2) Every group self-insured shall have actuarially determined financial strength sufficient to meet their obligations.

(3) The actuarial opinion and report required by NMSA 1978, Section 52-6-12, shall be filed annually and include the actuarial report from which the reserves for known claims and associated expenses and claims incurred but not reported and associated expenses were obtained.

(4) The group shall set rates utilizing the advisory loss costs published by the national council of compensation insurance, and adhere to uniform classification system, uniform experience rating plans, and manual rules filed with the superintendent of insurance, provided, however:

(a) Permission to apply premium discounts shall be requested by the group, subject to approval by the director, and shall be based on the group's expense levels and loss experience.

(b) Permission to make and use its own rates shall be requested by the group, subject to approval by the director and shall be based on at least three years of the group's experience.

(c) All requests for permission regarding rates or discounts shall be accompanied by an actuarial opinion supporting the request.

(d) Retroactive rate decreases and retroactive premium discounts are prohibited.

(e) All requests for rate reductions or premium discounts shall be approved or disapproved by the director within sixty (60) days after the submission of the request and any additional data requested by the director.

(5) [~~Each~~] Except as provided for in Section 52-6-5 B(1) NMSA 1978, each group shall annually certify to the director the group's continued compliance [~~with NMSA 1978, section 52-6-5 B(1)~~] member net worth requirements by submitting a compilation consisting of each member's assets, liabilities and net worth. No member's financial statements used for this compilation shall be more than 12 months old.

(6) In any month where the group's membership roster changes, each group shall submit to the administration an update of additions and deletions to the group's membership roster.

(7) Each group shall provide within 30 days of the end of each calendar quarter a roster of members including the number of employees employed by each member on the last day of the quarter.

(8) The group shall promptly notify the director of insolvencies or bankruptcies of members.

(9) The board of trustees shall adopt a policy statement regarding the admission to, or continued membership in, the group of any prospective member or current member with negative net worth. Such statement shall be provided to the director and to each member and prospective member of the group.

(10) Permission to declare and issue a dividend or refund shall be requested by the group not less than twelve months after the end of the fund year, subject to approval by the director, and shall be based on funds in excess of the amount necessary to fund all obligations for that fund year.

(a) All requests for dividend distributions shall be accompanied by financial information and an actuarial opinion supporting the request.

(b) All dividend refunds shall be approved or disapproved by the director within sixty (60) days after the submission of the request, and any additional data requested by the director.

(11) The group shall provide proof of [~~renewal of~~] coverage for all excess insurance policies and fidelity bonds[~~, or security~~] within [~~15~~] thirty (30) days of effective date or renewal, and [~~copies of all~~] complete excess insurance policies, and fidelity bonds [~~or security~~] within [~~45~~] ninety (90) days [~~of renewal~~]. Unauthorized changes appearing in any policy will require immediate remediation by way of retroactive reinstatement of approved terms or other measures deemed necessary by the director.

(12) The group must provide proof of renewal or replacement of posted security fifteen (15) days before expiration date.

(13) The group shall provide loss runs on a semi-annual basis on a format approved by the director, by January 31 and July 31 each year.

D. Certification: By signing and submitting an application, and as a condition of the continuing privilege of certification as a group self-insurer under the Group Self-Insurance Act, the group agrees to:

(1) promptly discharge all of the group's liabilities to injured employees or their dependents in accordance with the requirements of the Act and to comply with the Act and any rules of the director adopted thereunder;

(2) obtain the director's approval prior to making any change in any excess insurance policy, fidelity bond, or security which results in diminished coverage;

(3) notify the director of changes in the kind or amount of services provided by any third party claims administrator;

(4) promptly notify the director of any material change in the group's financial condition or group operations;

(5) cooperate fully with administration representatives in any evaluation or audit of the group self-insurance program, and to resolve, in good faith, issues raised in those evaluations or audits; it is specifically contemplated that such evaluation and audit issues may include notice of inadvertent or mistaken failures to pay benefits which were not paid when due, where no apparent ground existed at the time to contest the payment in good faith; failure to correct such inadvertent or mistaken failures to pay, after notice, may constitute a failure to resolve such audit issues in good faith in violation of this rule, and may result in any sanction appropriate under the group Self-Insurance Act; any dispute concerning issues raised shall be referred by the self-insurance bureau chief to the director for determination if not first informally resolved;

(6) the group shall be responsible for compliance with the act and the rules and shall be subject to sanction by the administration for acts or omissions in violation of the act or the rules by itself or by any person or entity acting in an agency relationship with the group; it shall be a defense to any sanction proposed that the group has appropriately fulfilled its duty to monitor, educate and control its agents; nothing in this rule is intended to alter the liability for workers compensation benefits of groups or their agents;

(7) The group agrees to comply with any requirements specified in the group's regular, probationary or provisional certificate of self-insurance.

E. Probationary certification: The group shall be responsible for compliance with the Act and the rules. Failure to comply with the Act or the rules may result in the issuance of a probationary certificate of group self-insurance.

(1) A probationary certificate means the revocation of the group's existing self-insurance certificate.

(2) The duration of the probationary period shall be within the director's discretion but shall not extend for more than one year's time.

(3) The group may be sanctioned for any violations that occur during the probationary period pursuant to NMSA 1978, section 52-6-21.

(4) If the group fails to come into compliance with the act and the rules by the end of the probationary period, the group's status as a self-insured may be revoked.

(5) All conditions of the act and the rules still apply and nothing in this rule is intended to alter the responsibilities for workers' compensation benefits of groups or their agents.

(6) The probationary certificate may be withdrawn and the original certificate of self-insurance may be reinstated if the group comes into full compliance with the Act and the rules. The reinstatement of the original certificate shall be at the sole discretion of the director.

(7) A probationary certificate of self-insurance shall be made by an order signed by the director or by his authority. Every such order shall state its effective date and

shall concisely state: what is ordered; the grounds on which the order is based; and the provisions of the act or rules pursuant to which the action is taken.

F. Waiver: Any requirement not mandated by statute contained in these rules may be varied or waived by specific written authorization of the director. Any interested person may request such a variance or waiver in writing.

[6/22/87, 6/23/87, 8/1/96, 11/15/96; 11.4.9.8 NMAC - Rn & A, 11 NMAC 4.9.8, 1/14/05; A, 12/29/06; A, 10/1/15]

End of Adopted Rules

This Page Intentionally Left Blank

Other Material Related to Administrative Law

WORKERS' COMPENSATION ADMINISTRATION

RESPONSE TO PUBLIC COMMENT ON PROPOSED RULEMAKING

The proposed changes to Parts 3, 4, 7, 8, 9 of the Workers' Compensation Administration ("WCA") Rules as well as several forms were released for public comment on July 15, 2015. The public comment period was from July 15, 2015 through August 14, 2015. In addition to written comments, the WCA accepted oral comment at a public hearing on August 6, 2015.

The undersigned appreciates all of those who took the time to submit comments regarding the proposed amendments.

PART 3

Comments were received in response to proposed changes to NMAC 11.4.3.11, which governs mileage benefits. Representatives for injured workers questioned whether a time limitation could be placed on mileage reimbursement. These commentators considered reimbursement for mileage to attend medical appointments a medical benefit, which are not subject to the statute of limitations. These commentators also expressed concern that limiting the time frame to submit reimbursement to 180 days was unfair to injured workers, who oftentimes are not informed of their right to mileage reimbursement. As an alternative proposal, several commentators suggested limiting the time to seek mileage reimbursement only where an employer or insurer has advised the worker of their right to reimbursement. Other alternative suggestions were to place a time frame of two years versus the proposed 180 day limit. One comment was received suggesting that the mileage reimbursement rate of $0.40 per mile be increased.

Comments in support of the proposed change were received from representatives for employers and insurers. These commentators explained that injured workers oftentimes hold reimbursement for several years or until the close of their claim, which then places a burden on insurer to administratively go back and verify dates of service and accuracy of reimbursement requested. In response to the alternative proposal, one commentator expressed concern that imposing an affirmative duty on the insurer would create additional burdens to notify the worker and to document the date of notice. Those who opposed and supported the proposed rule change agreed that passage of the rule could create additional litigation.

Response: Based on comments received, the WCA will withdraw the proposed rule amendments. The WCA appreciates the alternative suggestions and will consider the issue again in future rule making cycles.

Comments were received opposing the proposed amendment to NMAC 11.4.3.12, which in part governs an injured worker's obligation to provide a medical authorization to receive benefits. Commentators were also concerned about changes proposed to NMAC 11.4.4.9(F), which proposed to eliminate the requirement that the injured worker file an executed medical authorization at the time of filing a complaint or application. Commentators suggested that the rules should require submission of a current medical authorization form every time an initial pleading is filed because claims and litigation are lengthy and the forms become outdated. Comment was also received that use of "may" in paragraph A(4) was inconsistent with "shall" in paragraph A(5).

In conjunction with changes proposed to NMAC 11.4.3.12, a revised authorization to release medical records was also proposed. The revised medical authorization was generally well received, but all commentators expressed concern that the authorization would no longer be a mandatory form. One commentator thought the new authorization would make workers' compensation judges' jobs more difficult because the proposed rule and authorization form allow the worker's signature to be voluntary and would allow the worker to limit the time frames of records released. Other comments requested a worker's authorization be mandatory because comorbidities play a significant role in estimating costs of future medical care. Another commentator inquired why the WCA was proposing to revise the medical authorization form rather than holding providers and facilities accountable for refusing to accept the current mandatory authorization form.

The WCA also received various comments on the content of the proposed medical authorization form. Technical suggestions were made to remove or clarify certain language to make the authorization form more compliant with federal privacy laws and thus, more acceptable to health care providers and facilities.

Response: Based on comments received, the WCA is withdrawing the proposed amendments at 11.4.3.12(A)(5) and will continue to require that injured workers attach the mandatory WCA authorization form to release medical records when filing an initial pleading with the WCA. Amendments proposed to 11.4.3.12(A)(4) were intended to clarify that the authorization form an injured worker may be required to sign as a condition of receiving benefits is the mandatory form approved by the WCA. Amendments to 11.4.3.12(B)(2) will also be adopted as proposed. The proposed amendments are intended to avoid delays created when a health care provider will not accept the authorization form approved by the WCA. An employer cannot ask an injured worker to execute a medical authorization other than the WCA authorization form as a condition of receiving benefits. Not all health care providers fall under the jurisdiction of the WCA. The Veterans Hospital, for example, requires its own medical release. In those instances, a worker's claim should not come to a screeching halt because a health care provider insists on receiving a release that they believe fully complies with HIPAA and other laws.

Similarly, the medical authorization form was redesigned to address what have become common delays caused by providers and facilities not accepting the WCA authorization form. Under HIPAA, records of treatment for workers compensation injuries are exempt from federal privacy laws and are governed by state law. New Mexico law, Section 52-10-1 of the Workers' Compensation Act, states "[e]xcept for those records that are directly related to any injuries or disabilities claimed by a worker for which that worker is receiving benefits from his employer, the request shall be accompanied by a signed authorization for that request by the worker." Section 52-10-1 also provides that a health care

provider or facility shall immediately release to a worker, the worker's employer, or the employer's insurer all medical records, bills and other information concerning health care provided to an injured worker for injuries or disabilities claimed by a worker, without requiring a medical authorization from the worker. These laws were the basis for the WCA's proposal to no longer designate the medical authorization as an enumerated "mandatory form".

To address providers concerns and reduce delays that have begun to affect timely resolution of cases, especially claims involving IMEs, the WCA redesigned the medical authorization form. The new form incorporates suggestions that will, hopefully, make the WCA's approved form more acceptable to health care providers and facilities and avoid delays in processing record requests.

PART 4

Comments were received in response to amendments proposed to NMAC 11.4.4.9(E) and (F). Commentators expressed concern over the WCA's proposal to eliminate the current practice of having the injured worker attach a signed medical authorization to their initial pleading. Those opposed to the change felt that, unless the medical authorization was a mandatory form and attached to the worker's complaint, mediations would become meaningless and could potentially cause more litigation. One commentator noted she is seeing a lot of older claims come into disputed status and not having a current medical authorization attached to a complaint would cause delays and waste resources of the parties, mediators, and judges. Not having a current medical authorization was of particular concern for commentators who felt that they already face delays and challenges because they do not receive mandatory mediation production from the opposing party. As an alternative, some suggested the medical authorization form be submitted with the complaint but not filed or stored in the WCA's court file.

Response: Based on comments received, the WCA is withdrawing the proposed amendment to NMAC 11.4.4.9(F). A complete filing must include an executed medical authorization, if the complaint is filed by an injured worker. As noted above, the medical authorization to release medical records form will continue to be designated as a mandatory form in 11.4.4.9(E).

Comments were received on amendments proposed to NMAC 11.4.4.9(G), which governs service of process for initial pleadings. Commentators expressed concern about the appropriateness of shifting the burden of service to the filing party from the administration, which has more resources. Some also felt that requiring *pro se* workers to serve process on employers and insurers may become burdensome and could ultimately cause delays, especially where process has to be accomplished by publication. Commentators suggested the Clerk be allowed to publish or accomplish service by any other method contained in the rules of civil procedure for the district courts. Others suggested the agency adopt an electronic filing system similar to that adopted by district and federal courts. One commentator suggested that the agency mail endorsed copies of pleadings to the parties as a matter of course, because copies of pleadings are often not received in cases involving *pro se* workers.

Comments were also received questioning why the administration proposes that the filing party provide self-addressed, stamped envelopes. One commentator wondered if the request for stamped envelopes was an attempt by the WCA to not serve parties. Other comments suggested that requiring a party to provide envelopes when filing a complaint could prolong the litigation process. Comments were also received suggesting that keeping track of self-addressed envelopes seems like a challenge and waste of the administration's resources.

Response: The proposed amendments were intended to clarify the Clerk's obligation to serve process of initial pleadings. "Initial pleadings" under the proposed rule means a complaint, application, or petition that opens or reopens a case pending before the administration. When the Clerk cannot accomplish service by certified mail using the information provided by the filing party, the proposed rule gives the Clerk discretion to accomplish service of the initial pleading by any means allowed under the rule of civil procedure for the district courts, or to advise the filing party that service could not be accomplished. Setting an expectation that the filing party bears some responsibility to ensure their initial pleading is properly served on the responding party is consistent with service of process obligations in other courts. Based on comments received, the WCA will withdraw the amendment proposed at NMAC 11.4.4.9(G)(2). The rules to be adopted will codify the administration's current practice of requiring envelopes in conjunction with some filed pleadings. Self-addressed stamped envelopes are not required when filing a complaint, which is served on the parties of record simultaneously with the notice of mediation conference through certified mail by the WCA. Oftentimes when parties provide stamped envelopes when filing a complaint, the postage is incorrect so the envelope is not used. When a party files an application or petition, these initial pleadings are served certified mail by the Clerk before the endorsed request for setting and notice of hearing are mailed. Although an envelope is not needed for the Clerk to serve the application or petition by certified mail, an envelope should be submitted if the filing party requests a hearing or if the party requests the Clerk mail the parties of record a copy of the endorsed pleading.

Rule amendments proposed at 11.4.4.9(A)(2), which governs general rules for forms, filing, and hearing procedures, provide that any party who requests a hearing must also submit sufficient self-addressed stamped envelopes for all parties entitled to notice. This is an appropriate request of a filing party who seeks a hearing before the agency. For pleadings filed after the initial pleading, the parties may serve the pleading on the opposing party and execute a certificate of service, or the filing party can provide self-addressed stamped envelopes and request the Clerk complete the mailing of the endorsed pleading. A standard certificate of service has been added to some of the commonly filed mandatory forms for convenience of the parties who wish to serve the filed pleading themselves.

Comments were received regarding changes proposed to NMAC 11.4.4.9(H) and the proposed revised application to workers' compensation judge. One commentator inquired: who makes the decision that the application contains an issue outside of the enumerated list in NMAC 11.4.4.9(H)(1), the Clerk or someone else? Another commentator felt that the list of matters that can be pled by application is generally ignored by filing parties. Comments were also received indicating that the application to workers' compensation judge has become increasingly used in cases where the Clerk requires a complete filing package after

a case has been administratively closed. Commentators also wondered whether matters that could be raised by application could also be raised by motion, and suggestions were made that the deadline to respond to an application be the same 15 day deadline applicable for responses to motions.

Suggestions were also made that application for physical examination of worker and application to consolidate payments be removed from the application form, because they are rarely used. Other comments were received suggesting that an "other" option be added to the application and requiring additional information for more frequently sought relief, such as IMEs.

Response: Applications are an exception to the general rule that disputes be raised through a filed complaint. Applications were always intended to address finite, specific issues where requiring the parties to go through the mediation process would be unreasonable. Matters that may be raised by application to workers' compensation judge are limited to those matters contained in the enumerated list found at NMAC 11.4.4.9(H)(1). For this reason, the application to workers' compensation judge form will not be amended to add an "other" option.

The practice of filing applications during the pendency of a complaint has sometimes created confusion regarding service of process, including whether a new summons is necessary. When the Clerk receives an application to workers' compensation judge for filing, the application is processed as an application and assigned to a judge. After assignment to a workers' compensation judge, if the judge notes the matters raised in the application fall outside the enumerated list, the judge may order the application be deemed a complaint and refer the parties to mediation conference. This process seems to be working well. The responsibility to ensure that matters raised in applications fall within the enumerated list falls first on the shoulders of the parties and second on the shoulders of the workers' compensation judge assigned to hear the application.

Based on comments, the WCA will add a new subparagraph, NMAC 11.4.4.10(H)(4) to provide "following the rejection of a recommended resolution, and during the pendency of a complaint, the forms of relief enumerated under 11.4.4.9(H) shall be sought through motion." Changing the deadline to respond to applications from 10 days to 15 days is consistent with the new rule allowing parties to file motions for any matter that may be raised by application, when a complaint is already pending.

Comments were received in response to amendments proposed at NMAC 11.4.4.9(I) and NMAC 11.4.4.13(A)(5), which govern petitions for lump sum payments and on call judge assignments, and in response to proposed revisions to the mandatory forms. Several comments were submitted expressing concern that the proposed rule at NMAC 11.4.4.9(I)(3) is inconsistent with established case law and policy – i.e., *Sommerville*. Specifically, commentators stated that a hearing is required for all lump sum settlements petitions in accordance with *Sommerville.* Others felt that the proposed rule change permitting hearings to be held at the WCJ's discretion could lead to a conflict when the parties believe a hearing is necessary and the WCA does not. One commentator suggested the administration review the public policy underlying the *Sommerville* case and require a hearing on the record for all lump sum petitions. Another commentator stated he was unaware that a judge had discretion to decide whether a hearing was necessary. One written comment stated that the rule requiring a proposed order was not necessary when filing a petition and recommended striking the proposed language and replacing it with the language "All petitions shall be accompanied by a summons, if applicable, and a request for setting and notice of hearing."

Concerns were also expressed on amendments proposed at NMAC 11.4.4.9(I)(4) and suggested that it was unnecessary to require a workers' attorney to file an application for attorneys' fees in addition to a petition for lump sum payment. Opponents of the proposal thought the rule would unnecessarily increase filings at the WCA and create additional burdens on the parties.

Comments were also received on the WCA's proposal to codify the current practice for "Lump-Sum Tuesdays." Some commentators questioned why the voluntary, walk-in lump sum hearings were open to petitions filed under Section 52-5-12(B) and (C), rather than restricting the voluntary process to joint petitions for lump sum under Section 52-5-12(D). One comment suggested the process had out lived its usefulness.

For each of the joint petition for lump sum forms, comments were received suggesting the WCA include a place to insert the total amount of settlement and the net recovery to a worker, as well as Medicare set-aside language. Regarding the Section 52-5-12(D) petition, many comments were received indicating the current form is confusing and unworkable. Various deletions and revisions were suggested.

Response: The proposed rule merely restates the statutory requirements regarding hearings on petitions for lump sum payment. Section 52-5-12(D) of the Workers' Compensation Act is clear that petitions filed pursuant to that subparagraph may be approved only after hearing on the record. The statute does not require a hearing for other types of lump sum petitions, but leaves it up to the assigned judge. See Section 52-5-13. If the parties request a hearing when filing their petition, it is presumed the workers' compensation judge will notice a hearing. Similarly, if the parties present a proposed order when filing their lump sum petition and the assigned judge is satisfied the worker understands the terms and conditions of the lump sum, Section 52-5-13 grants the judge discretion to hold or not hold a hearing. To avoid confusion, the WCA will clarify that the discretion granted in Section 52-5-13 applies only to joint lump sum petitions.

Concerns over the language proposed at 11.4.4.9(I)(4) were well received. The proposed amendment will be revised to clarify that a separate application for attorneys' fees is not required. Regarding Lump Sum Tuesday, the WCA will continue to allow parties to present joint petitions for lump sum payment on a voluntary, walk-in basis. Any joint, lump sum petition that is stipulated by the parties, including Section B, C, and D, may be heard as part of this procedure.

Regarding proposed revisions to the mandatory lump sum petition forms, the suggested revisions are well received and the WCA will revise these forms shortly.

Comments were received in response to amendments proposed at NMAC 11.4.4.9(P)(3), which governs withdrawal and substitution of counsel. One commentator questioned why the length of time an attorney is considered the attorney of record after closure of a case was doubled from six months to one year.

The commentator expressed concern that such a time frame would place additional burdens on attorneys, who often lose track of their clients after a case is resolved.

Response: The rule currently provides that six months after closure of the case by order or recommended resolution, notice of any subsequent pleadings will be sent to the named party. In most cases, the parties are represented by the same attorneys for the duration of the claim. In most courts, the attorney of record remains the attorney of record until permitted to substitute or withdraw by the court. Past experience has shown that most subsequent complaints are filed between six months and one year from the case closure. As a result, notices were not being sent to attorneys of record, which caused mediations to be rescheduled resulting in delays. The amendment will hopefully reduce such delays when a subsequent complaint is filed.

Comments were received in response to amendments proposed at NMAC 11.4.4.10(B), which governs mandatory production. Comments suggested revising the rule to only require production of medical bills in possession of a party.

Response: Based on comments received, NMAC 11.4.4.10(B)(1) will be amended and provide that parties shall exchange mandatory production in their possession.

Comments were received in response to amendments proposed at NMAC 11.4.4.10(D)(5), which governs recommended resolutions. Commentators expressed concern the WCA proposed to remove the following: "Failure to timely accept or reject the recommended resolution shall conclusively bind the parties to the recommended resolution."

Response: The referenced sentence was stricken because it is unnecessary. The binding effect of a party's failure to reject the recommended resolution is already stated in statute. See Section 52-5-5.

Comments were received in response to amendments proposed to add a new section governing director's matters, NMAC 11.4.4.11. Commentators expressed concern that judge assignment disputes would be decided by the director. These commentators felt that judge assignment disputes should be handled by a workers' compensation judge and that the WCA is required to follow the district court rules and case law, which provide that judge assignment disputes are resolved by the judge that was excused. Concern was also expressed that decisions of the director may not be appealable under case law. Concerns were also expressed that the proposed rule raises constitutional issues because the Workers' Compensation Act provides that cases are assigned to a judge after the rejection of a recommended resolution. Others commented it was helpful to have guidance on the use of the process for applications to the director.

Regarding NMAC 11.4.4.11(C)(2)(g), comments were received that a child 16 years of age should not be allowed to apply for death benefits for lack of capacity and that the proposed provision may conflict with NMSA 1978, §52-5-17. This commentator also suggested adding a new paragraph that would require the WCA notify a payer about the receipt or approval of accountings or suspension of benefit payments to minors or incompetent workers. Another commentator felt the director should have authority to assign cases to a workers' compensation judge under this section even if a case was not already pending before a workers' compensation judge. Comments indicated that the ability to appoint a third-party professional to receive and manage death benefits is a positive development. Another comment stated the Director's handling of objections to referral for nurse case management makes sense. Other commenters suggested this rule be withdrawn.

Response: NMAC 11.4.4.11 codifies the agency's current processes and provides clarity on which matters should be heard by the director. It is true that the Workers' Compensation Act does not provide a statutory right to appeal decisions of the director to the Court of Appeals. However, decisions of administrative agencies are generally appealable to district courts when there is no statutory right of appeal.

The concerns expressed about the director's authority to resolve judge assignment disputes were addressed during the WCA's rule making cycle in 2014. As was explained in the director's response to public comment last year, NMAC 11.4.4.12(C)(4) clarifies the avenue for resolving a dispute about the assignment, re-assignment, or disqualification of workers' compensation judges. The WCA has used various methods to handle these types of disputes over the years—each with its drawbacks—and all without apparently having a written, codified rule. The codified rule clarified the process, centralized it, and avoids putting judges or parties in untenable or uncomfortable situations when furthering arguments. NMAC 11.4.4.12(C)(4) is the WCA's current rule. Further, the WCA is not part of the judiciary. Thus, judicial rules or case law discussing how the judiciary handles judge assignment issues are instructive, but not binding on the WCA. NMAC 11.4.4.11(1) simply lists judge assignment disputes as a matter to be pleaded by application to the director, consistent with NMAC 11.4.4.12(C)(4). Section 52-5-11 of the Workers' Compensation Administration Act allows the director to authorize benefit payments directly to a minor or incompetent person. NMAC 11.4.4.11(C)(2)(g) simply sets a minimum age that the director may consider authorizing benefit payments to a minor child. Payers of benefits receive notice of hearings when a recipient is proposed and when benefits may be suspended due to failure to provide accountings, or other reasons. Payers who wish to receive quarterly or annual benefit accountings may request copies from the WCA's Office of General Counsel.

In response to amendments proposed at NMAC 11.4.4.13(A), formerly (C), which governs the time to disqualify a judge, comments were received expressing concern that the proposed amendment appears to strike the ten day waiting period to disqualify a judge. Commentators thought this was unnecessary and may slow the resolution process, particularly in the context of a Section 52-5-12(D) joint petition.

Response: The intent of this amendment is to clarify that if the parties want to expedite matters, they need to jointly agree to waive their right to excuse a judge, particularly in cases involving joint petitions for lump sum payments. The ten day waiting period is nothing more than a directive to the assigned judge that he or she should take no action on a case for ten days in order to allow all parties the right to excuse a judge. If a party waives its right to excuse a judge, the party has also waived the ten day waiting period. Having separate waivers is superfluous. If one party files a waiver of its right to excuse a judge, the judge would still have to wait ten days to allow the other party or parties time to file an excusal. As long as both parties jointly agree to waive their right to disqualify a judge, the assigned judge may proceed without delay.

PART 7

Comments were received in response to amendments proposing to repeal the rule requiring implementation of electronic billing, NMAC 11.4.7.8(C)(16). One comment supported removing the rule because the language is too vague to enable proper stakeholder compliance. The commenter suggested the adoption of an electronic billing regulatory framework in the future, such as the IAIABC model rule or standards set by the National Council for Prescription Drug Programs (NCPDP). Other comment suggested that the e-billing requirement be implemented but delayed since providers already electronically bill group health, Medicare and Medicaid claims, but acknowledged that medical records are not required for those systems.

Response: The rule requiring electronic billing is repealed but may be reintroduced in the future.

Comments were received in response to amendments proposed at NMAC 11.4.7.9(C)(4), which governs payment of medications. Commenters pointed out that the New Mexico billing process for pharmaceuticals should be examined as they lack specificity and there is no designated form or format for billing of drugs, medications, and pharmacy services. Concern was expressed that the proposed rule creates opportunities for non-pharmacists to provide compounded medicines. One written comment suggested that the proposed language could lead to abuse and cost inflation due to over-utilization of compounds. Commenters noted that IAIABC and NCPDP provide model rule language, form, formats and guidance for billing medications and recommended that the WCA adopt a similar approach.

Several comments suggested various iterations of alternative language at 11.4.7.9C(4), including: "the ingredients of a compounded mediation shall be paid in accordance with the fee schedule. Reimbursement shall be at the ingredient level with each ingredient identified using the applicable National Drug Code (NDC) of the ingredient and the corresponding quantity and in accordance with the fee schedule and billing instructions. Any ingredient which lacks an NDC shall not be reimbursed." Commentators stated that billing at the ingredient level allows for precise pricing and reimbursement based on component NDCs and other covered components and provides greater transparency and accuracy, allows identification of the discrete treatment specifics, and enables fraud detection. Other commenters suggested the medications be paid in accordance with the fee schedule. It was also suggested that the WCA require that compound medications receive prior authorization before they are dispensed.

Response: The current health care provider fee schedule authorizes health care providers to dispense compound medications, up to a ten (10) day supply. By striking "prepared by a pharmacists," the rule will be consistent with the fee schedule. The WCA will consider comments submitted when proposing the 2016 health care provider fee schedule. The rule will be adopted as proposed.

Comments were received in response to new regulations proposed to govern medical cannabis reimbursement, NMAC 11.4.4.7 and 11.4.7.9(D). Support and concern was expressed with regard to the proposed rule. Those in support of the proposed rule stated it was a good start to a complex issue. Those in opposition focused their comments on the requirement for employers, through their insurers, to pay for a drug that is illegal under federal law. Opponents of the rule mentioned several consequences, including jeopardized eligibility for federally-based programs, exposure to criminal prosecution at the federal level, exposure to civil racketeering (RICO) lawsuits filed on behalf of anti-marijuana and/or other stakeholder groups, and aiding and abetting and conspiring in the commission of a federal crime defined by the Controlled Substances Act. Suggestions were made that New Mexico follow other jurisdictions that have statutorily exempted insurance companies and employers from the requirement to pay for this treatment in order to avoid the legal quagmire. A concern was also expressed about work place safety because Colorado courts have had to address issues involving workplace deaths where the worker used marijuana. Some recommended the WCA remain silent on the issue in its rules and seek a legislative remedy to exempt payment for this treatment until federal law changes and the efficacy of medical cannabis is proven.

Other commentators expressed concern that the proposed regulations are not consistent with New Mexico's adoption of the ODG guidelines – medical cannabis is not a recommended treatment under ODG. Commentators expressed concern over the dissonancy between medical cannabis and ODG but also recognized ODG is only a "positive affirmation" and not a means to deny treatment, so providers will have to provide appropriate rationale for the referral to the cannabis program. Others expressed concern that the safety and efficacy of medical cannabis to treat diseases or medical conditions has not been proven and that there are no National Drug Codes (NDCs) assigned to medical marijuana. Others commented that approval of medical cannabis to treat "chronic pain" has not been obtained. Payers inquired whether they would receive a CMS-1500 or a version of the HCPDP forms or a drug billing with NDCs and whether the WCA would establish state specific NDC type codes (if billed as a drug) or CPTs (if billed as a medical procedure treatment)? Some believe that utilization and cost containment issues may also arise.

Regarding the specifics of the proposed rule and fee schedule, many questions were posed. Commentators inquired how the WCA plans to include medical cannabis in the providers' fee schedule when there are diverse types of marijuana for purchase, including edible varieties. One written comment specifically expressed that payers should not have to pay for any form of edibles. With respect to the documentation that must be furnished, some commentators inquired what the provider would need to furnish to show that "other treatment methods have failed." One commentator thought the requirement that "other treatment methods have failed" is contrary to the Court of Appeals decision in *Reilly v. Maes*. This commentator asked what constitutes failing and what if the worker prefers medical cannabis to narcotics?

Changes and alternative suggestions were also proposed. One commenter suggested a new subparagraph at 11.4.7.9D(1)(e): "Only medical cannabis provided by a licensed producer shall be permitted and shall be eligible for reimbursement." Some suggested paraphernalia should be defined and that it should be clearly stated if a delivery mechanism is covered. Additionally, one commentator suggested the rule address reimbursement of the annual membership fee for the medical cannabis program.

Response: The proposed rule arises out of Court of Appeals decisions that held employers may be required to reimburse medical

cannabis as a reasonable and necessary medical treatment for a work place injury. As an administrative agency, the WCA is charged with enforcing the laws passed by the legislature and interpreted by the courts. One of the WCA's statutory responsibilities involves controlling medical costs and proposing fee schedules. The proposed rule regarding medical cannabis is offered as a compromise and to provide some guidance to workers and payers. The rule delineates certain eligibility requirements for reimbursement of medical cannabis and follows a method similar to the rules governing travel reimbursement to attend medical appointments.

Based on comments suggesting the rule define "paraphernalia", the WCA will adopt the proposed rule with the following amendment at 11.4.7.9(D)(2)(e) – "reimbursement for paraphernalia*, as defined in the Controlled Substances Act, Section 30-31-2(V) NMSA 1978,* shall not be reimbursed." Based on questions inquiring how the WCA will determine fees for reimbursement, the WCA will adopt the proposed rule with the following amendment at 11.4.7.9(D)(2)(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* and form of medical cannabis purchased, and the purchase price." Other comments received regarding the fee schedule will be considered as the WCA considers the 2016 Health Care Provider Fee Schedule.

Comments were received in response to amendments proposed to NMAC 11.4.7.13, which governs non-clinical service fees of health care providers, and revisions to the Form Letter to Health Care Provider. One commentator stated that there is no CPT code for medical records and there is no NM fee schedule placer code for medical records or a corresponding fee associated with such a service. One commentator requested guidance in situations where facilities receive multiple requests. Comment was received that, while the fee for copying medical records was removed from Part 7, it is not contained in the fee schedule so there is no guidance during the interim period.

Comment was also received regarding the proposed rule allowing HCPs to charge for up to three hours of preparation time for a deposition. Concern was raised that the rule will increase the cost of depositions and litigation, in general, and may lend itself to abuse since some physicians are rarely prepared for their depositions. One commentator questioned how payers would recoup the payment if the HCP was clearly not prepared for the deposition after charging for prep time. If the HCP gave testimony favorable to the party it would not behoove the party to contest the prep fee. Commenters believe that some medical offices would begin routinely charging for the prep time. Commenters recommended that the deposition preparation fee proposal be stricken and that the deposition fees should be increased to $500 for the first hour and $460 for the second hour, noting that the fee had not been increased in recent years. Those concerned about discovery costs suggested the WCA revisit the $3,000 discovery costs in the next 60-day legislative session. One comment stated that allowing an HCP to be paid for preparation time for deposition testimony is a long-overdue change.

Comments were also received regarding proposed changes to the Form Letter to Health Care Provider. A suggestion was made to add language to the form providing that employer be billed for the cost of the form letter. Some commentators questioned what the new fee would be since the amount will not be released until the fee schedule is released. Another commentator expressed concern that form letters were not returned even though the check for completion was cashed, and inquired how to address those issues.

<u>Response</u>: Based on comments received, the WCA withdraws its proposal to strike 11.4.7.13(A); costs for copying medical records will remain in the rules, rather than in the separate fee schedule. Regarding deposition preparation time, concerns have been expressed for many years suggesting that health care providers should be compensated for time spent preparing for deposition. Because deposition preparation time has not been allowed under the rules, physicians often appear for deposition without having familiarized themselves with the worker's chart. The WCA hopes that by permitting health care providers to bill preparation time for depositions, depositions will be shorter and of better quality. Asking a deponent what he or she has done to prepare for deposition is a standard deposition question, and one that may alleviate concern regarding improper billing. In the event the physician's testimony is inconsistent with a bill for preparation time, the parties may bring the issue to the director's attention as a billing dispute. Increased costs may also encourage the parties to be more selective about which depositions they notice.

Based on comments regarding the Form Letter to Health Care Provider, the WCA withdraws its proposal to strike 11.4.7.13(B) and will replace it with the following "a practitioner may charge for the completion of the form letter to health care provider the amount set forth in the fee schedule." The WCA will also add an instruction directing the physician completing the form to submit the bill to the claims administrator. When billing disputes arise, including disputes over completion of form letters, parties may bring those issues to the attention of the director through a medical billing dispute, or to the assigned workers' compensation judge.

<u>PART 8 AND 9</u>

No comments were received regarding amendments proposed to Part 8 or Part 9. The rules will be promulgated as proposed.

<u>FORMS</u>

Comments were received in response to proposed revisions to the forms for approval of out of state health care providers. Supportive comments received noted that the proposed form is cleaner and easier to understand than the current forms. Another commentator expressed concern that the application to director to approve an out of state health care provider required an affidavit from the out of state provider. This commentator expressed concern that obtaining an affidavit from an out of state health care providers may be difficult when the providers will not participate in the discovery process and sometimes send bills to injured workers.

<u>Response</u>: The current rule for approval of out of state health care providers requires that the request be supported by an affidavit, which will now be attached to the application. If an out of state health care provider renders services to an injured worker and the employer/insurer pays for those services, NMAC 11.4.7.10(D) provides that the director's approval of the provider is deemed given for that worker and no filings are necessary.

Publication in the New Mexico Register

These rules will be adopted pursuant to NMSA 1978, §52-5-4. The final rules contain the proposed amendments published and opened for public comment and the revised rules following public comment as discussed above.

The public record of this rulemaking shall incorporate this Response to Public Comment and the formal record of the rulemaking proceedings shall close upon execution of this document.

Electronically signed

DARIN A. CHILDERS, Director
N.M. Workers' Compensation Administration
September 16, 2015

End of Other Material Related To Administrative Law

New Mexico Register
Submittal Deadlines and Publication Dates
Volume XXVI, Issues 1-24
2015

Volume XXVI	Submittal Deadline	Publication Date
Issue 1	January 2	January 15
Issue 2	January 16	January 30
Issue 3	February 2	February 13
Issue 4	February 16	February 27
Issue 5	March 2	March 16
Issue 6	March 17	March 31
Issue 7	April 1	April 16
Issue 8	April 17	April 30
Issue 9	May 1	May 14
Issue 10	May 15	May 29
Issue 11	June 1	June 16
Issue 12	June 17	June 30
Issue 13	July 1	July 15
Issue 14	July 16	July 30
Issue 15	July 31	August 14
Issue 16	August 17	August 28
Issue 17	August 31	September 15
Issue 18	September 16	September 29
Issue 19	September 30	October 15
Issue 20	October 16	October 29
Issue 21	October 30	November 16
Issue 22	November 17	November 30
Issue 23	December 1	December 15
Issue 24	December 16	December 30

The ***New Mexico Register*** is the official publication for all material relating to administrative law, such as notices of rulemaking, proposed rules, adopted rules, emergency rules, and other material related to administrative law. The Commission of Public Records, Administrative Law Division, publishes the ***New Mexico Register*** twice a month pursuant to Section 14-4-7.1 NMSA 1978.

The New Mexico Register is available free online at **http://www.nmcpr.state.nm.us/nmregister.**
For further information, call 505-476-7942