TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 21 HEALTH CARE SERVICES AND PROVIDER CREDENTIALING REQUIRED FOR HMOs

13.10.21.1 ISSUING AGENCY: Public Regulation Commission, Insurance Division.
[13.10.21.1 NMAC - N, 09/01/2009]

13.10.21.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer, or administer health care coverage pursuant to the health maintenance organization (HMO) laws of the state of New Mexico:

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

(1) only short-term travel, accident-only, student health, specified disease, or other limited benefits; or

(2) credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit, including a stand-alone dental benefit plan, whether indemnity, PPO, or non-profit plan.

C. Conflicts. For purposes of this rule, if any provision in this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care, 13.10.16 NMAC, Provider Grievances, or 13.10.17 NMAC Grievance Procedures Rule, the provisions in this rule shall apply.
[13.10.21.2 NMAC - N, 09/01/2009]

13.10.21.3 STATUTORY AUTHORITY: Sections 59A-2-8, 59A-2-9, 59A-4-4, 59A-4-5, 59A-15-16, 59A-16-13.1, 59A-22- 41.1, 59A-22-43, 59A-46-2, 59A-46-4, 59A-46-7, 59A-46-23, 59A-46-30, 59A-46-35, 59A-46-36, 59A-46-38.2, 59A-46-38.4, 59A-46-38.5, 59A-46-39, 59A-46-41, 59A-46-41.1, 59A-46-42, 59A-46-42.2, 59A-46-43, 59A-46-43.2, 59A-46-44, 59A-46-45, 59A-46-46, 59A-46-48, 59A-46-49, 59A-57-4, and 59A-57-6 NMSA 1978.
[13.10.21.3 NMAC - N, 09/01/2009]

13.10.21.4 DURATION: Permanent.
[13.10.21.4 NMAC - N, 09/01/2009]

13.10.21.5 EFFECTIVE DATE: September 1, 2009, unless a later date is cited at the end of a section.
[13.10.21.5 NMAC - N, 09/01/2009]

13.10.21.6 OBJECTIVE: The purpose of this rule is to clarify what is meant by a basic health care plan, for the purposes of certification of a health care plan as a health maintenance organization (HMO), pursuant to the requirements of Section 59A-46-2 NMSA 1978.
[13.10.21.6 NMAC - N, 09/01/2009]

13.10.21.7 DEFINITIONS: In addition to the following, this rule is subject to the definitions found in 13.10.17 NMAC and to the definitions in 59A-46-2 NMSA 1978 and 59A-46-7 NMSA 1978.

A. "Credentialing" means the process of obtaining and verifying information about a health professional and evaluating that health professional when that health professional applies to become a participating provider with an HMO.

B. "Credentialing intermediary" means a person to whom an HMO has delegated credentialing or recredentialing authority and responsibility.

C. "Health maintenance organization (HMO)" means any person who undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for covered person responsibility for copayments or deductibles.

D. "Health care professional" means physicians, dentists, registered nurses, licensed practical nurses, podiatrists, optometrists, chiropractic physicians, physician assistants, nurse anesthetists, certified nurse practitioners, certified nurse-midwives, registered lay midwives, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists, doctors of oriental medicine, and other professionals engaged in the delivery of health care services who are licensed to practice in New Mexico, are certified, and are practicing under the authority of an HMO.

E. "Primary care practitioner" means physicians, other health care professionals such as doctors of oriental medicine, chiropractic physicians, nurse practitioners, physician assistants, or certified nurse midwives who may provide primary care, provided that the health care practitioner: 1) is acting within his or her scope of practice as defined under the relevant state licensing law; 2) meets the HMO eligibility criteria for health care practitioners who provide primary care; and 3) agrees to participate and to comply with the health care insurers or HMO care coordination and referral policies.

F. "Quality assurance plan" means the internal ongoing quality assurance program of an HMO to monitor and evaluate the HMO's health care services, including its system for credentialing health professionals applying to become a participating provider with an HMO or otherwise providing services to the HMO's covered persons.

G. "Uniform credentialing forms" means the version current at the time of the application or re-application process of forms used either by the hospital services corporation (HSC) or council for affordable quality healthcare universal credentialing datasource (CAQH), including any revisions thereto and as developed and updated from time to time, and including electronic versions of such forms.

H. "Women's health care practitioner" means obstetricians-gynecologists, family practitioners, general practitioners, certified nurse midwives, other physicians specializing in women's health, and physician assistants or nurse practitioners specializing in women's health. An HMO may also make registered lay midwives available to female covered persons for prenatal care and delivery. The HMO may assure that those providers who seek to provide self-referral women's services who are not obstetricians-gynecologists or who are not practicing under the supervision of obstetricians-gynecologists have the requisite background, training, and experience to properly examine and treat self-referred female covered persons.

I. "Written notification" as between the MHCP and providers means a writing delivered through standard U.S. postal service, or through other written means if agreed upon by the parties as effective alternative methods of communication for the intended purpose, including but not limited to personal delivery service, facsimile delivery, or electronic mail.

[13.10.21.7 NMAC - N, 09/01/2009]

13.10.21.8 HMO BASIC HEALTH CARE SERVICES: A health care insurer offering basic health care services through an HMO shall provide or shall arrange for the following medically necessary basic health care services for its covered persons.

A. An HMO may not provide or arrange to provide basic health care services if such services:

(1) do not include all the basic health services set forth in this section; or

(2) are limited as to time or cost except as prescribed in this section, subject to lifetime policy maximums.

B. Outpatient medical services: Outpatient medical services shall include those hospital services that can reasonably be provided on an ambulatory basis, and those preventive, medically necessary, and diagnostic and treatment procedures that are prescribed by a covered person's primary care or attending health care professional. Such services may be provided at a hospital, a physician's office, any other appropriate licensed facility, or at any other appropriate facility if the health care professional delivering the services is licensed to practice, is certified, and is practicing under authority of the health care insurer or HMO, a medical group, an independent practice association or other authority authorized by applicable New Mexico law.

C. Inpatient hospital services: Inpatient hospital services shall include, but not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by the covered person's primary care practitioner or treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary.

D. Emergency and urgent care services: Emergency and urgent care services shall include:

(1) acute medical care that is available twenty-four hours per day, seven days per week, so as not to jeopardize a covered person's health status if such services were not received immediately; such medical care shall include ambulance or other emergency transportation; in addition, acute medical care shall include, where appropriate, transportation and indemnity payments or service agreements for out-of-service area or out-of-network coverage in cases where the covered person cannot reasonably access in-network services or facilities; and

(2) coverage for trauma services at any designated level I, level II, or other appropriately designated trauma center according to established emergency medical services triage and transportation protocols; coverage for

trauma services and all other emergency services shall continue at least until the covered person is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending physician or health care professional in consultation with the HMO; if the health care insurer or HMO requests transfer to a hospital participating in its provider network, the patient must be stabilized and the transfer effected in accordance with federal law. See 42 CFR 489.20 and 42 CFR 489.24;

(3) reimbursement for emergency care and emergency transportation shall not be denied by the health care insurer or HMO when the covered person, who in good faith and who possesses average knowledge of health and medicine, seeks medical care for what reasonably appears to the covered person to be an acute condition that requires immediate medical attention, even if the patient's condition is subsequently determined to be non-emergent;

(4) in determining whether care is reimbursable as emergency care, the MHCP shall take the following factors into consideration:

(a) a reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment;

(b) the time of day the care was provided;

(c) the presenting symptoms; and

(d) any circumstances which precluded use of the HMO's established procedures for obtaining emergency care;

(5) reimbursement for emergency care shall not be denied in those instances when the covered person is referred to emergency care by the covered person's primary care practitioner or by the HMO;

(6) no prior authorization shall be required for emergency care. In addition, appropriate out-of-network emergency care shall be provided to a covered person without additional cost; whether out-of-network emergency care is appropriate shall be determined by the standards of Paragraph (4) of Subsection D of 13.10.21.8 NMAC.

E. Short-term rehabilitation services and physical therapy: Short-term rehabilitation services and physical therapy shall be provided in those instances where the covered person's primary care practitioner or other appropriate treating health care professional determines that such services and therapy can be expected to result in the significant improvement of a covered person's physical condition within a period of two months. Such services may be extended beyond the two month period upon recommendation by the primary care practitioner in consultation with the HMO.

F. Diagnostic services: Diagnostic services shall include diagnostic laboratory services, diagnostic and therapeutic radiological services, and other services in support of comprehensive basic health care services.

G. Other mandated benefits: Any and all mandated benefits pursuant to federal or state law that apply to HMOs which become effective following promulgation of this rule, and the following:

(1) dental services:

(a) when determined to be medically necessary by a participating provider in connection with the following: accidental injury to sound natural teeth, the jaw bones, or surrounding tissues; the correction of a non-dental physiological condition which has resulted in a severe functional impairment; or the treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(b) general anesthesia and hospitalization, pursuant to Section 59A-46-48 NMSA 1978;

(2) reconstructive surgery: surgery from which an improvement in physiologic function could reasonably be expected, when ordered by a covered person's primary care practitioner or treating health care professional and performed for the correction of functional disorders resulting from accidental injury or from congenital defects or disease;

(3) diabetes care: for insulin-using individuals, non-insulin-using individuals and those with elevated blood glucose levels induced by pregnancy, coverage pursuant to Section 59A-46-43 NMSA 1978;

(4) medical diets: for genetic inborn errors of metabolism, medical diets pursuant to Section 59A-46-43.2 NMSA 1978;

(5) craniomandibular and temporomandibular joint disorders: for surgical and nonsurgical treatment of temporomandibular joint disorders and craniomandibular disorders, subject to the same conditions, limitations, prior review and referral procedures as are applicable to treatment of any other joint in the body, pursuant to Section 59A-16-13.1 NMSA 1978;

(6) cancer clinical trials: routine patient care costs incurred as a result of the patient's participation in a phase II, III or IV cancer clinical trial, pursuant to Section 59A-22-43 NMSA.

H. Children's health care: Children's health care shall include, but not be limited to:

(1) childhood immunizations, pursuant to Section 59A-46-38.2 NMSA 1978;

(2) vision and hearing testing for persons through age 17 to determine the need for vision and hearing corrections;

(3) well-child care from birth in accordance with recommendations of the American academy of pediatrics;

(4) prenatal care, including medically necessary nutritional supplements prescribed by the expectant mother's obstetrician-gynecologist, or other health care professional from whom the expectant mother is receiving prenatal care, if maternity coverage is provided by the HMO;

(5) availability of educational materials or consultation from providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of tobacco use, nutrition and diet recommendations, exercise plans, and, as deemed appropriate by the primary care practitioner or as requested by the parents or legal guardian, educational information on alcohol and substance abuse, sexually-transmitted diseases, and contraception;

(6) hearing aid coverage, pursuant to Section 59A-46-38.5 NMSA 1978; and

(7) circumcision for newborn males, pursuant to Section 59A-46-38.4 NMSA 1978.

I. Women's health care: Women's health care coverage shall be included in all HMOs, and shall include, at a minimum, the following:

(1) mammograms, pursuant to Section 59A-46-41 NMSA 1978;

(2) cytologic and human papillomavirus screening, pursuant to Section 59A-46-42 NMSA 1978;

(3) osteoporosis services, defined as diagnosis, treatment, and appropriate management of osteoporosis when such services are determined to be medically necessary by a covered person's primary care practitioner in consultation with the HMO;

(4) alpha-fetoprotein IV screening, pursuant to Section 59A-46-46 NMSA 1978;

(5) limitation on visits: an HMO may limit the number of visits to designated women's health care providers by female covered persons, provided that it allows:

(a) at least one routine annual well-visit per female covered person; and

(b) follow-up treatment within sixty days following a well-visit for treatment of a condition diagnosed during a well-visit.

J. HMOs providing maternity coverage: If an HMO provides maternity benefits, the coverage shall include:

(1) medically necessary prenatal, intrapartum, and perinatal care;

(2) smoking cessation treatment, pursuant to Section 59A-46-45 NMSA 1978; and 13.10.18.8 NMAC;

(3) maternity transport, pursuant to Section 59A-46-39 NMSA 1978; and

(4) minimum hospital stays and postpartum care, pursuant to federal law and 13.10.2 NMAC.

K. HMOs providing mastectomy coverage: Each HMO which provides mastectomy coverage shall also cover mammography for screening and diagnostic purposes, prosthetic devices, and reconstructive surgery, as mandated by federal or state laws.

L. Direct access to women's health care practitioners: A female covered person whose primary care practitioner is not a women's health care practitioner shall have direct and timely access to an in-network, participating women's health care practitioner for women's health care coverage, as defined at Subsection I of 13.10.21.7 NMAC. Direct access shall also be offered by an HMO that offers additional obstetric and gynecological services beyond those required under this rule, or that offers maternity coverage.

(1) Disclosure. Each managed health care plan shall disclose to covered persons in clear, accurate language, the right of female covered persons age 13 and over of direct access to an in-network, participating women's health care practitioner of her choice. The information shall include, at a minimum, any specific women's health care services excluded from coverage, and shall include reference to the HMO's right to limit coverage to medically necessary and appropriate women's health care services.

(2) Co-payments. No HMO shall impose additional copayments, co-insurance, or deductibles for female covered persons' direct access to in-network, participating women's health care providers when acting as a PCP.

(3) Choice to become a PCP. Nothing in this section requires any women's health care provider to enter into a contract with an HMO whereby he or she must act as a primary care practitioner (PCP) rather than as a referral specialist.

(4) Criteria for PCP acceptance. An HMO's criteria for accepting women's health care providers as PCPs must be the same as the criteria utilized by the HMO for other specialists seeking to act as PCPs.

(5) Procedure for direct access. Any female covered person age 13 or older shall have direct access to women's health care by:

(a) including qualified women's health care providers as primary care practitioners (PCPs), which means that the women's health care provider has met the HMO's general eligibility criteria for a specialist seeking PCP status, and agrees with the HMO to comply with its coordination and referral policies;

(b) allowing female covered persons to select a qualified women's health care practitioner as their PCP; and

(c) allowing female covered persons who have not chosen a women's health care provider as their PCP to self-refer, without requiring prior authorization or pre-approval from the plan or their PCP, to an in-network, participating women's health care practitioner for women's health care and, if offered as a covered benefit under the plan, for maternity care and additional obstetric and gynecological services, subject to the following:

(i) self-referrals shall be limited to those services defined by the published recommendations of the American college of obstetrics and gynecology;

(ii) the HMO may require the women's health care practitioner to discuss with the female covered person's PCP any services or treatment the women's health care practitioner recommends for the covered person.

(iii) the women's health care practitioner must comply with the HMO's coordination and referral policies.

M. Health promotion program: Each HMO that provides coverage for comprehensive basic health care services in this state shall provide a preventative health services program and shall make the following services available to a covered person only in those instances where the covered person's primary care practitioner determines that such services are medically necessary:

(1) periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, a fractionated cholesterol level including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level, in accordance with recommendations of the U.S. preventive services task force;

(2) periodic glaucoma eye tests for all persons 35 years of age or older, in accordance with recommendations of the U.S. preventive services task force;

(3) periodic stool examinations for the presence of blood for all persons 50 years of age or older, in accordance with recommendations of the U.S. preventive services task force;

(4) colorectal cancer screening, in accordance with the recommendations of the U.S. preventive services task force, pursuant to Section 59A-46-48 NMSA 1978;

(5) immunizations for all adults, as recommended by the CDC advisory committee for immunization practice;

(6) for all persons 20 years of age or older and as deemed medically necessary by a primary care practitioner, an annual consultation with a health professional to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat-belts in motor vehicles, and other preventative health care practices;

(7) other preventative health services shall include, under a covered person's primary care practitioner's supervision:

(a) reasonable physical and behavioral health appraisal examinations and laboratory and radiological tests on a periodic basis when medically necessary;

(b) voluntary family planning services; and

(c) diagnosis and medically indicated treatments for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery.

[13.10.21.8 NMAC - Rp, 13.10.13.9 NMAC, 09/01/2009]

13.10.21.9 UNIFORM PROVIDER CREDENTIALING FOR HEALTH MAINTENANCE ORGANIZATIONS (HMOs):

A. Delegation of credential verification activities: Whenever an HMO delegates credential verification activities to a contracting entity, whether a credentialing intermediary or subcontractor, the HMO shall review and approve the contracting entity's credential verification program before contracting and shall require that the entity comply with all applicable requirements of this regulation. The HMO shall monitor the contracting entity's credential certification activities. The HMO shall implement oversight mechanisms, including (a) reviewing the contracting entity's credential verification plans, policies, procedures, forms, and adherence to verification

procedures, (b) requiring the contract entity to submit an updated list of health professionals no less frequently than quarterly, and (c) conducting an evaluation of the contracting entity's credential verification program at least every two years. The HMO's monitoring activities should at least meet the verification procedures and standards as defined by the national committee for quality assurance (NCQA).

B. Credential verification program: In order to assure accessibility and availability of services, each HMO shall establish a program in accordance with this regulation that verifies that its network providers are credentialed before the HMO lists those providers in the HMO's provider directory, handbooks, or other marketing or member materials. The credential verification program established by each HMO shall provide for an identifiable person or persons to be responsible for all credential verification activities, which person or persons shall be capable of carrying out that responsibility.

C. Written credential verification plan: Each HMO shall develop and adopt a written credentialing plan that contains policies and procedures to support the credentialing verification program. The plan shall include the purpose, goals and objectives of the credential verification program; and the roles of those persons responsible for the credential verification program.

D. Use of uniform credentialing forms required: Beginning September 1, 2009, an HMO shall not use any health professional credentialing application form other than uniform HSC or CAQH credentialing or re-credentialing forms. Should the superintendent determine that these forms no longer represent industry standards, the superintendent will issue a bulletin advising of alternative forms to be used to satisfy this requirement. The uniform credentialing or re-credentialing forms may be used in electronic or paper format, as determined by the HMO. An HMO shall not require an applicant to submit information not required by the uniform credentialing or re-credentialing forms. An exception is made for health professionals who: (a) are subject to credentialing under the HMO's internal policy; (b) practice outside of New Mexico; and (c) prefer to use the credentialing forms required by their respective states. In such circumstances, the HMO and its delegated entity, if any, may accept those forms.

E. Verification of credentials: Each HMO shall maintain a process to assess and verify the qualifications of health professionals applying to become participating providers with the HMO within 45 calendar days of receipt of a completed uniform credentialing form. Each HMO's process for verifying credentials shall take into account and make allowance for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials, and shall make allowance for the scheduling of a final decision by a credentialing committee, if the HMO's credentialing program requires such review.

(1) Within 45 calendar days after receipt of a completed application and all supporting documents, the HMO shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 45th calendar day after receipt of the application, the HMO has not received all of the information or verifications it requires from third parties, or date-sensitive information has expired, the HMO shall issue a written notification, through standard mail, fax, electronic mail or other agreed-upon writing, to the applicant either closing the application and detailing the HMO's attempts to obtain the information or verification, or pending the application and detailing the HMO's attempts to obtain the information and verifications. If the application is held, the HMO shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and telephone number of a credentialing staff person who will serve as a contact person for the applicant.

(2) Within 10 working days after receipt of an incomplete application, the HMO shall notify the applicant in writing of all missing or incomplete information or supporting documents.

(a) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as the contact person for the applicant.

(b) Within 45 calendar days after receipt of all of the missing or incomplete information or documents, the HMO shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with Subsection E of this section.

(c) If the missing information or documents have not been received within 45 calendar days after initial receipt of the application or if date-sensitive information has expired, the HMO shall close the application or delay final review, pending receipt of the necessary information. The HMO shall provide written notification to the applicant of the closed or pending status of the application and, where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as the contact person for the applicant.

(3) If an HMO elects not to include an applicant in its network, for reasons that do not require review of the application, the HMO shall provide written notice to the applicant of that determination within 10 working days after receipt of the application.

(4) Nothing in this regulation shall require an HMO to include a health professional in its network or prevent an HMO from conducting a complete review and verification of an applicant's credentials, including an assessment of the applicant's office, before agreeing to include the applicant in its network.

(5) Nothing in this regulation shall be deemed to supersede any provision of a contract between an HMO and a health professional participating as a provider in the HMO's network.

(6) HMOs must notify a provider at least 120 days in advance of all items necessary to complete recredentialing. The HMO must complete the recredentialing process within 45 days of receipt of the provider's complete recredentialing application and all supporting documents.

F. Health professional files: Each HMO shall maintain centralized files, either paper or electronic, on each health professional making application to be a participating provider in the HMO's network. Each file shall include documentation of compliance with this regulation.

G. Records and examinations: Each HMO shall maintain all records related to credential verification in a manner that the HMO deems to be adequate for a period of six years and shall make such records available to the superintendent on request.

H. Accreditation by nationally recognized accrediting entity: Nothing in this section shall prohibit an HMO from submitting accreditation by a nationally recognized accrediting entity as evidence of compliance with the requirements of this section. In those instances where an HMO seeks to meet the requirements of this section through accreditation by a private accrediting entity, the HMO shall submit to the division the following information: 1) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule; 2) documentation from the private accrediting entity showing that the HMO has been accredited by the entity; and 3) a summary of the data and information that was presented to the private accrediting entity by the HMO and upon which accreditation of the HMO was based. An HMO accredited by the private accrediting entity that has submitted all of the requisite information to the division may then be deemed by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the HMO obtained accreditation is recognized and approved by the superintendent.

[13.10.21.9 NMAC - N, 09/01/2009]

13.10.21.10 PENALTIES: In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurer by the superintendent in accordance with Sections 59A-1-18, 59A-46-25, and 59A-57-11 NMSA 1978.

[13.10.21.10 NMAC - Rp, 13.10.13.32 NMAC, 09/01/2009]

13.10.21.11 SEVERABILITY: If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.21.11 NMAC - Rp, 13.10.13.33 NMAC, 09/01/2009]

HISTORY OF 13.10.21 NMAC:

Pre-NMAC History: none.

History of Repealed Material: [RESERVED]

NMAC History:

Only those applicable portions of 13.10.13 NMAC, Managed Health Care (filed 4/13/2007) were renumbered, amended, and replaced by 13.10.21 NMAC, Health Care Services and Provider Credentialing Required for HMOs, effective 09/01/2009.