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New Mexico Register

Volume XXXV, Issue 23
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Notices of Rulemaking and Proposed Rules

Adopted Rules

A = Amended, E = Emergency, N = New, R = Repealed, Rn = Renumbered

Notices of Rulemaking and Proposed Rules

ENVIRONMENT DEPARTMENT

NEW MEXICO ENVIRONMENTAL IMPROVEMENT BOARD NOTICE OF CANCELLATION OF STATE IMPLEMENTATION PLAN AND RULEMAKING HEARING

The New Mexico Environmental Improvement Board hereby provides notice that the public hearing noticed on October 8, 2024, in Issue 19 of the New Mexico Register and scheduled to begin on December 18, 2024, at 9:00 a.m. to consider EIB 24-49 (R) – In the Matter of Regional Haze State Implementation Plan Revision for the Second Planning Period and Proposed Companion Rule 20.2.68 NMAC – Regional Haze Requirements, has been cancelled. This hearing will be rescheduled and noticed again at a later date.

AVISO DE CANCELACIÓN DEL PLAN DE IMPLEMENTACIÓN ESTATAL Y AUDIENCIA DE ELABORACIÓN DE NORMAS DE LA JUNTA DE MEJORA AMBIENTAL DE NUEVO MÉXICO

La Junta de Mejora Ambiental de Nuevo México notifica por el presente aviso que la audiencia pública notificada el 8 de octubre de 2024 en la edición 19 del Registro de Nuevo México y programada para comenzar el 18 de diciembre de 2024 a las 9:00 a. m. para considerar la EIB 24-49 (R) – En el Asunto de la Revisión del Plan de Implementación Estatal de la Contaminación Atmosférica Regional para el Segundo Período de Planificación y la Norma Complementaria Propuesta 20.2.68 NMAC – Requisitos de la Contaminación Atmosférica Regional, ha sido cancelada. Esta audiencia será reprogramada y será notificada nuevamente en una fecha posterior.

GAMING CONTROL BOARD

NOTICE OF PROPOSED RULEMAKING

The Gaming Control Board hereby gives notice that the Board, at a Regular Board Meeting open to the public, will consider public comments received and determine whether to adopt the described rules below.

The Regular Board Meeting will be held on Wednesday, January 15, 2024 beginning at 9:00 am at the Gaming Control Board, 4900 Alameda Blvd. NE, Albuquerque, NM 87113. Interested individuals may also attend via Zoom as follows:

https://us06web.zoom.us/j/85909302122?pwd=UKa28nW0AZurFQDYYssCfGVWbDmoxf.1
Meeting ID: 859 0930 2122
Passcode: 8Bh6th

The public comment period for this rulemaking closed with the public comment hearing which occurred on June 11, 2024.

Subsection B of 15.1.2.8 NMAC Confidential Information:

Purpose: Repeal current Rule and replace with cleaned up language in the rule.

Summary of Full Text: Changing "operation of gaming establishments" to "gaming operations."

15.1.3.8 NMAC - Adoption, Amendment and Repeal

Purpose: Repeal current Rule and replace with a correction of the statutory reference in the rule.

Summary: Changing 60-2E-61 NMSA 1978 to 60-2E-62 NMSA 1978.

Subsection D of 15.1.6.8 NMAC - Suitability of Premises

Purpose: Repeal current Rule and replace to connect rule to statute.

Summary: Adds reference to statutory definition of "permanent physical barrier".

Subsections B and E of 15.1.6.9 NMAC - Area of Licensed Premises; Restrictions:

Purpose: Repeal current Rule and replace to clarify requirements for gaming premises constructions and reiterates tie to statute.

Summary: Specifies that gaming premises construction needs to be completed in accordance with applicable building codes and a certificate of occupancy has been issued along with Board approval prior to gaming commencing on the licensed premises. Also adds reference to the statutory definition of "permanent physical barrier."

Subsections A, D, and E of 15.1.6.10 NMAC - Ownership of Premises

Purpose: Repeal current Rule and replace with same version but requiring disclosure of all potential applicable business relationships.

Summary: Requires disclosure of business relationships "in addition to the lease" between the licensee or applicant and the lessor "or owner" of the premises, adds requirement to disclose liens, clarifies that written board approval is required for a change in premises lease, ownership of, or interest in gaming premises.

Subsection B, C, D of 15.1.6.11 NMAC - Modification of Licensed Premises.

Purpose: Repeal current Rule and replace original rule with same version but adding cross-references to other rules and removing certain requirements for premises modifications.

Summary: Adds requirement to comply with 15.1.5.28 NMAC in addition to this rule in Subsection B. Changes "this rule" to "these rules" in Subsection C. Removes requirement that modifications of licensed premises must be approved by the Board prior to such modification in Subsection D.

15.1.6.12 NMAC - Transfer of License to New Premises.

Purpose: Repeal current Rule and replace with new title that better describes the rule and removing redundant language.

Summary: Changes "License" to "Gaming Operations" in the title. Removes "or license" and changes "an unapproved" to "a different" premises in Subsection A. Removes "or the gaming operator's license" in Subsection B.

Consideration of Subsection D of 15.1.10.32 NMAC - Definitions, included with the public comment notice, has been withdrawn due to the incorrect rule cited in the original notice.

Consideration of Subsections C, D, and F of 15.1.2.9 NMAC - Requests for Disclosure of Confidential Information, included with the public comment notice, has been withdrawn and will be reconsidered at a later date after due notice is given.

Authority: Section 60-2E-7 NMSA1978 and Section 60-2E-8 NMSA 1978.

All written public comments are posted on the website throughout the written comment period at: https://www.gcb.nm.gov/rulemaking/.

Any person with a disability who needs a reader, amplifier, qualified sign language interpreter, or auxiliary aid or service to attend or participate in the hearing should contact (505) 841-9700.

GAMING CONTROL BOARD

NOTICE OF CANCELLATION OF RULE HEARING

The Gaming Control Board rule hearing previously scheduled to take place on Wednesday, December 4, 2024, at 9:00 A.M., has been canceled due to publication issues. The meeting and rule hearing will be rescheduled to a future date as appropriate.

GAMING CONTROL BOARD

NOTICE OF PROPOSED RULEMAKING

The Gaming Control Board hereby gives notice that the Board will conduct a public comment hearing on the described rules below.

The public comment hearing will be held on Monday, January 13, 2025 from 9:00 am to 12:00 pm at the Gaming Control Board, 4900 Alameda Blvd. NE, Albuquerque, NM 87113. Interested individuals may also attend via Zoom as follows:
Join Zoom Meeting
https://us06web.zoom.us/j/83192153102?pwd=P1ANokRQ4lxeQYm2Ui8jgSGvS5s3uS.1

Meeting ID: 831 9215 3102
Passcode: 9q73R2

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• +1 669 444 9171 US
• +1 646 558 8656 US (New York)
• +1 646 931 3860 US
• +1 689 278 1000 US
• +1 301 715 8592 US (Washington DC)
• +1 305 224 1968 US
• +1 309 205 3325 US
• +1 312 626 6799 US (Chicago)
• +1 360 209 5623 US
• +1 386 347 5053 US
• +1 507 473 4847 US
• +1 564 217 2000 US

Meeting ID: 831 9215 3102
Passcode: 209874

The public comment hearing allows members of the public an opportunity to submit data, testimony, and arguments in person on the proposed rule changes detailed below. All comments will be recorded by a court reporter and/or audio recording.

Subsections D and E of 15.1.5.15 NMAC Compulsive Gambling Assistance Plan:

Purpose: Amend rule to make it more current and applicable.

Summary of Full Text: Changing mandate for board to establish minimum standards for a compulsive gambling assistance plan, because it has already been done, to requiring applicants for gaming operator licenses to comply with those requirements. Also capitalizes "Department of Health"

15.1.5.23 NMAC - Application Fees:

Purpose: Amends rule to update requirements concerning applications and application fees.

Summary of Full Text: Updates application fee amounts that have not been changed since the inception of the agency and removes the requirement that the board must immediately issue an order denying an applicant for a gaming license at any time in the application process should they be deemed not qualified.

Subsection D of 15.1.6.7 NMAC – Definitions

Purpose: Repeal current Rule and replace with corrections of spelling/ grammatical errors.

Summary: Changing "building's" to "buildings" in definition of "premises".

Subsection B of 15.1.18.9 NMAC – Minimum Standards for Compulsive Gambling Assistance

Purpose: Repeal and replace current rule to update it.

Summary: Capitalizes "Department of Health" and makes it the responsibility of the Gaming Control Board's Responsible Gaming Coordinator to evaluate and made a recommendation to the Board as to a Compulsive Gambling Assistance Plan.

Authority: Section 60-2E-7 NMSA 1978 and Section 60-2E-8 NMSA 1978.

Details for Obtaining a Copy of Rule and Submitting Oral or Written Comments:
Copies of the proposed rules are available on the Gaming Control Board's website at https://www.gcb.nm.gov/rulemaking/ or can be obtained by emailing GCB-PIO@gcb.nm.gov. The proposed rules are also available on the New Mexico Sunshine Portal. Interested individuals may provide comments at the public hearing. Before the public hearing, written comments may be sent to GCB-PIO@gcb.nm.gov, or by regular mail at Attn: Michelle Pato - proposed rule, The Gaming Control Board, 4900 Alameda Blvd. NE, Albuquerque, NM 87113. The deadline to receive written comment is Monday, January 13, 2024. All written public comments will be posted on the website throughout the written comment period at: https://www.gcb.nm.gov/rulemaking/.

Any person with a disability who needs a reader, amplifier, qualified sign language interpreter, or auxiliary aid or service to attend or participate in the hearing should contact (505) 841-9700.

PUBLIC EDUCATION DEPARTMENT

AMENDED NOTICE OF PROPOSED RULEMAKING

Public Hearing

The hearing date and public comment period previously published in Issue 21 on Nov. 5, 2024, is being changed and this rule will now be heard on Friday, January 10, 2025, rather than on the originally noticed hearing date of December 6, 2024.

The New Mexico Public Education Department (PED) gives notice that it will conduct a public hearing for the following proposed rulemaking on Friday, January 10, 2025, from 1:30 p.m. to 2:30 p.m. (MDT) in Mabry Hall, located in the Jerry Apodaca Education Building, 300 Don Gaspar Ave., Santa Fe, New Mexico 87501:

Amendment of 6.29.1 NMAC, General Provisions

The PED will give a verbal summary statement, on record, at the hearing.

The purpose of the public hearing is to receive public input on the proposed rulemaking. Attendees who wish to provide public comment on record will be given three minutes to make a statement concerning the proposed rulemaking. To submit written comment, please see the Public Comment section of this notice.

Explanation of Purpose of Rulemaking, Summary of Text, and Statutory Authority, by Proposed Rule

6.29.1 NMAC, General Provisions
Explanation: The proposed amendment would align the rule with legislation enacted during the 2024 legislative session, HB171, Graduation Requirements, and SB137, School Board Training, and revise provisions regarding special education modified diplomas. New proposed language to the amendment further clarifies school board training requirements and provisions regarding modified diplomas.
Summary: The proposed amendment would update graduation requirements, school board and governing council training requirements, and available diploma options for students in special education. New proposed language to the amendment refines school board training terminology and details provisions regarding modified diplomas.
Statutory Authority: Sections 9-24-8, 22-2-1, 22-2-2, 22-2-2.1, 22-2C-3, 22-2C-4, 22-5-13, 22-13-1.1, and 22-13-14 NMSA 1978.

No technical information served as a basis for this proposed rule change.

Public Comment

Interested parties may provide comment at the public hearing or may submit written comments by mail or e-mail.

Mailing Address
Policy and Legislative Affairs Division
New Mexico Public Education Department
300 Don Gaspar Avenue, Room 121
Santa Fe, New Mexico 87501
E-Mail Address
Rule.Feedback@ped.nm.gov

Written comments must be received no later than 5 p.m. (MDT) on Friday, January 10, 2024. The PED encourages the early submission of written comments.

Public Comment Period

The public comment period is from Tuesday, December 10, 2024 to Friday, January 10, 2025, at 5:00 p.m. (MDT). The PED will review all feedback received during the public comment period and issue communication regarding a final

decision of the proposed rulemaking at a later date.

Copies of the proposed rule may be obtained from Denise Terrazas at (505) 470-5303 during regular business hours or may be accessed through the PED Police and Legislative Affairs webpage titled, "Proposed Rules," at http://webnew.ped.state.nm.us/bureaus/policy-innovation-measurement/rule-notification/.

Individuals with disabilities who require the above information in an alternative format or need any form of auxiliary aid to attend or participate in the public hearing are asked to contact Denise Terrazas at (505) 470-5303 as soon as possible before the date set for the public hearing. The PED requires at least 10 calendar days advance notice to provide any special accommodations requested.

HEALTH CARE AUTHORITY
INCOME SUPPORT DIVISION

NOTICE OF PUBLIC HEARING

Each year there is a requirement to update the SNAP, NMW, Education Works Program, and General Assistance Programs income limits for participation, resource eligibility standards and deduction amounts available to otherwise eligible households. These amounts are determined by the United States Department of Agriculture (USDA) and Food and Nutrition Services (FNS). The Authority received notification of the adjusted amounts on August 13, 2024, and made the adjustments effective for benefit month October 2024 for Federal Fiscal Year (FFY) 2025 to comply with federal law and regulations.

The Health Care Authority (HCA) through Income Support Division (ISD) is proposing amendments to update annual adjustments to the income limits found in 8.102.500 NMAC and 8.106.500 NMAC and to increase the gross monthly income Federal Poverty Limit (FPL) from 165% to 200%. This increase applies to eligible SNAP cases based on Broad Based Catergorial Eligibility (BBCE) policy found in 8.139.100 NMAC; 8.139.120 NMAC; 8.139.400 NMAC; and 8.139.420 NMAC. The Authority is also proposing amendments to 8.106.631 Heat and Eat Program to update FPL language from 165% to 200%.

A hybrid public hearing to receive testimony on this proposed rule will be held, pursuant to Section 14-4-5.6 NMSA 1978, on Friday, January 10, 2025, at 10:30 a.m. - 11:30 a.m. You may join in person, virtually, or by phone.

You may join in person at:
HCA Administrative Services (ASD) conference room, 1474 Rodeo Road, Santa Fe, NM 87505.

You may join virtually from your computer, tablet or smartphone:
Microsoft Teams
Join the meeting now
Meeting ID: 267 090 256 519
Passcode: H2xX3v

You may join by phone:
+1 505-312-4308,,646365616#
United States, Albuquerque
Find a local number
Phone conference ID: 646 365 616#

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 American Disabilities Act Coordinator, at Office-505-709-5468, Fax-505-827-6286 or through the New Mexico Relay system, toll free at #711. The Department requests at least a 10-day advance notice to provide the requested alternative formats and special accommodations.

Written comment may be dropped off during the scheduled hearing time at the HCA Administrative Services Division (ASD) conference room, 1474 Rodeo Road, Santa Fe, NM 87505 if the individual wishes to provide written comment during the scheduled hearing. All written comments will be posted on the agency website within 3 days of receipt.

Individuals wishing to testify may contact the Income Support Division (ISD), P.O. Box 2348, Santa Fe, NM 87504-2348, or by calling (505) 670-1791.

Individuals who do not wish to attend the hearing may submit written or recorded comments. Written or recorded comments must be received by 5:00 p.m. on the date of the hearing, January 10, 2025. Please send comments to:

Income Support Division
P.O. Box 2348
Santa Fe, NM 87504-2348

Recorded comments may be left at (505) 670-1791. You may send comments electronically to: HCA-isdrules@hca.nm.gov. Written and recorded comments will be given the same consideration as oral testimony made at the public hearing.

End of Notices of Rulemaking and Proposed Rules

Adopted Rules

Effective Date and Validity of Rule Filings

Rules published in this issue of the New Mexico Register are effective on the publication date of this issue unless otherwise specified. No rule shall be valid or enforceable until it is filed with the records center and published in the New Mexico Register as provided 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.

ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT
STATE PARKS DIVISION

The Energy, Minerals and Natural Resources Department approved at its 10/22/2024 hearing, to repeal its rule 18.17.2 NMAC, Boating Operation and Safety, and replace it with 18.17.2 NMAC, Boating Operation and Safety, adopted on 11/14/2024 and effective 1/1/2025.

The Energy, Minerals and Natural Resources Department approved at its 10/22/2024 hearing, to repeal its rule 19.5.1 NMAC, General Provisions, filed 12/31/1996, and replace it with 19.5.1 NMAC, General Provisions, adopted on 11/14/2024 and effective 1/1/2025.

ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT
STATE PARKS DIVISION

TITLE 18 TRANSPORTATION AND HIGHWAYS
CHAPTER 17 NAVIGATION AND BOATING
PART 2 BOATING OPERATION AND SAFETY

18.17.2.1 ISSUING AGENCY: Energy, Minerals and Natural Resources Department.
[18.17.2.1 NMAC – Rp, 18.17.2.1 NMAC, 1/1/2025]

18.17.2.2 SCOPE: 18.17.2 NMAC applies to persons using vessels in the waters of New Mexico.
[18.17.2.2 NMAC – Rp, 18.17.2.2 NMAC, 1/1/2025]

18.17.2.3 STATUTORY AUTHORITY: Section 66-12-18 NMSA 1978 authorizes the state parks division to promulgate rules to carry into effect the provisions of the Boat Act, Sections 66-12-1 *et seq*. NMSA 1978.
[18.17.2.3 NMAC – Rp, 18.17.2.3 NMAC, 1/1/2025]

18.17.2.4 DURATION: Permanent.
[18.17.2.4 NMAC – Rp, 18.17.2.4 NMAC, 1/1/2025]

18.17.2.5 EFFECTIVE DATE: January 1, 2025 unless a later date is cited at the end of a section.
[18.17.2.5 NMAC – Rp, 18.17.2.5 NMAC, 1/1/2025]

18.17.2.6 OBJECTIVE: 18.17.2 NMAC's objective is to set forth registration requirements for vessels and to promote safety for persons and property in and connected with vessels' use, operation and equipment.
[18.17.2.6 NMAC – Rp, 18.17.2.6 NMAC, 1/1/2025]

18.17.2.7 DEFINITIONS:

A. "Certificate of number" means the registration certificate required to operate a motorboat on the waters of New Mexico.

B. "Combination lights" means lights required on vessels operating on the waters of New Mexico in the hours of darkness, green on the starboard (right) side and red on the port (left) side and shall throw the lights from dead ahead to two points abaft of the beam on their respective sides.

C. "Department" means the energy, minerals and natural resources department.

D. "Director" means the director of the energy, minerals and natural resources department, state parks division.

E. "Division" means the energy, minerals and natural resources department, state parks division.

F. "Human-powered watercraft" means a vessel that is propelled by human power through the use of hands or feet, oars, paddles, poles or pedals, but not sails or an engine.

G. "Paddle craft" means any type of canoe, kayak, paddleboard or other vessel powered only by its occupants using a single or double-bladed paddle as a lever without the aid of a fulcrum provided by oarlocks, tholepins, crutches or similar mechanisms.

H. "Person" means an individual, partnership, firm, corporation, association, joint venture or other entity.

I. "Personal flotation device" means a U.S. coast guard approved personal floatation device used in accordance with its U.S. coast guard approved label.

J. "Personal watercraft" means a class A motorboat less than 16 feet, designed to be operated by a person sitting, standing or kneeling on the vessel rather than the operator sitting or standing inside the vessel. Examples include jet skis, sea doos, wave runners and similar devices.

K. "Power driven vessel" means any vessel propelled by machinery at the time of operation.

L. "Registration" means the process by which motorboats owned by persons domiciled in New Mexico and motorboats not registered in another state nor by the United States, which are operated on the waters of this state are numbered as evidenced by a

certificate of number issued by the New Mexico taxation and revenue department under a joint powers agreement with the department.

M. **"Right of way"** means the right of a vessel, which is proceeding on an established forward course at a relatively constant speed to continue such course unchanged without reducing speed, turning, veering or reversing.

N. **"Secretary"** means the secretary of the energy, minerals and natural resources department.

O. **"Superintendent"** means a division employee who is in charge of a specific park.

P. **"Vessel"** means every description of watercraft, other than a seaplane on the water, used or capable of being used as a means of transportation on water.

Q. **"Wake"** means white water created from wave action breaking off the vessel's bow or sides.

[18.17.2.7 NMAC – Rp, 18.17.2.7 NMAC, 1/1/2025]

18.17.2.8 REGISTRATION:

A. **Certificate of number:** In accordance with the Boat Act, boats operating on waters of the state shall be numbered and the certificate of number shall be available for inspection at all times when the motorboat is in operation. Every certificate of number except those issued to dealers and manufacturers expires on December 31 of the third calendar year of registration. Registration shall be renewed triennially. Refunds shall not be made for any unused period of a certificate of number due to non-use of a vessel or change in ownership. No person shall transfer or authorize the transfer of a registration validation decal from one vessel to another.

B. **Registration number:** A motorboat's registration number shall be painted on or permanently affixed to each side of the motorboat's forward half, and no other number shall be displayed on that part of the motorboat. Numbers shall: read from left to right; be in plain vertical block characters; be of a color contrasting with the background; be distinctly visible and legible; be not less than three inches in height; and have spaces or hyphens that are equal to the width of a letter between the letter and number groupings. Example: NM 0000 AA or NM--0000--AA. The validation sticker shall be affixed within six inches to the right of the registration number on the port side of the vessel.

C. **Dealer registrations:** A dealer's certificate of number shall be on board each vessel being demonstrated. Dealer numbers shall be displayed and mounted temporarily on such vessels. The dealer number shall not be affixed permanently on a vessel. An individual dealer shall not demonstrate more than three vessels at any one time.

D. **Registration fees:**

CLASS	MOTORBOAT LENGTH	THREE YEAR COST
A	Less than 16 ft.	$60.00
1	16 ft. to less than 26 ft.	$75.00
2	26 ft. to less than 40 ft.	$120.00
3	40 ft. to less than 65 ft.	$150.00
	65 ft. or over	$180.00
	Duplicate Registration	$25.00

[18.17.2.8 NMAC – Rp, 18.17.2.8 NMAC, 1/1/2025]

18.17.2.9 EQUIPMENT REQUIRED TO OPERATE A VESSEL: No person shall operate or give permission to operate a vessel on the waters of this state that is not equipped as required by 18.17.2.9 NMAC and the Boat Act.

A. **Flotation devices:**

(1) Vessels shall carry a U.S. coast guard approved wearable personal flotation device of proper size and fit for each person on board or being pulled as a skier, plus one U.S. coast guard approved throwable device. A throwable device is not required for personal watercraft, kayaks, canoes, paddleboards, wind sail boards, inner tubes, air mattresses, float tubes, rubber rafts or other inflatable watercraft. Personal flotation devices and throwable devices shall be in serviceable condition readily accessible for use and shall bear evidence of U.S. coast guard approval. Personal flotation devices and throwable devices shall be carried and used in accordance with any requirements on the approval label.

(2) Skiers and those being pulled on a floating object shall wear a U.S. coast guard approved wearable personal flotation device while being pulled by a vessel.

(3) Vessels that carry passengers for hire shall provide a U.S. coast guard approved wearable personal flotation device for each person on board. Vessels shall carry an additional number of approved wearable personal flotation devices of children size equal to at least 10 percent of the total number of persons carried unless the service is such that children are never carried.

(4) Persons engaged in boating on a river or in boat races or persons using human-powered

watercraft, ice sailboats, personal watercraft, kayaks, canoes, paddleboards and rubber rafts on any waters of this state shall wear a U.S. coast guard approved wearable personal flotation device.

(5) Persons using wind sail boards, inner tubes, air mattresses, float tubes or other inflatable devices not covered in Paragraph (4) of Subsection A of 18.17.2.9 NMAC on waters of this state shall wear a U.S. coast guard approved wearable personal flotation device of the proper size and fit and in accordance with any requirements on the approved label.

(6) The operator of a vessel used for recreational purposes shall require children age 12 or under who are aboard the vessel to wear a personal flotation device approved by the United States coast guard while the vessel is underway, unless the child is below deck or in an enclosed cabin.

B. Fire extinguisher:

(1) Vessels constructed with any of the following characteristics shall be equipped with serviceable U.S. coast guard approved marine fire extinguisher of a size and in a quantity set forth in Paragraph (2) of Subsection B of 18.17.2.9 NMAC:

(a) inboard engine;

(b) closed compartments under thwarts and seats where portable fuel tanks may be stored;

(c) double bottoms not sealed to the hull or that are not completely filled with flotation material;

(d) closed living spaces;

(e) closed storage compartments in which combustible or flammable materials may be stored; or

(f) permanently installed fuel tanks.

(2) Fire extinguisher requirements by boat length:

CLASS	LENGTH OF MOTORBOAT	NUMBER OF EXTINGUISHERS REQUIRED	SIZE OF FIRE EXTINGUISHERS
A	Less than 16 feet	One	5-B
1	16 feet to less than 26 feet	One	5-B
2	26 feet to less than 40 feet	Two or One	5-Bs or 20-B
3	40 feet or more	Three or One	5-Bs or 20-B

(3) Disposable (non-rechargeable) fire extinguishers meeting this requirement shall be not more than 12 years old from the date stamped on the bottle.

C. Sound producing devices: Vessels shall carry on board a sound producing device in accordance with the following minimum requirements:

(1) less than 26 feet (this includes kayaks, canoes, paddleboards and rubber rafts): mouth, hand or power operated whistle or other sound producing mechanical device capable of producing a blast of two second duration and audible for at least one-half mile;

(2) 26 feet but less than 40 feet: hand or power operated horn or whistle capable of producing a blast of two seconds or more duration and audible for a distance of at least one mile and a bell;

(3) 40 feet or more: power operated horn or whistle capable of producing a blast of two seconds or more duration and audible for a distance of at least one mile and a bell.

D. Flame arrestor: Enclosed gasoline engine carburetors (except outboard motors) installed in a vessel shall be equipped with a U.S. coast guard approved backfire flame arrestor that is marked with a U.S. coast guard approval number or in compliance with UL 1111 tests or the standard SAE J-1928, MARINE.

E. Water closets: No person shall maintain or operate a vessel on the waters of this state equipped with a water closet unless the closet is self-contained and incapable of discharging directly into the water.

F. Lights:

(1) Power driven vessels operating one-half hour after sunset to one-half hour before sunrise or during times of poor visibility shall display a combination light on the vessel's fore part and a white light aft to show 360 degrees around the vessel's horizon and above the combination light. The combination light shall be green on the starboard (right) side and red on the port (left) side and shall throw the lights from dead ahead to two points abaft of the beam on their respective sides.

(2) A sailing vessel underway one-half hour after sunset to one-half hour before sunrise or during times of poor visibility shall exhibit lights as required below or by U.S. coast guard rule.

(a) A sailing vessel of seven meters in length or more shall exhibit sidelights and a sternlight.

(b) A sailing vessel of less than seven meters in length shall, if practicable, exhibit sidelights and a sternlight, but if she does not, she shall exhibit an all-round white light or have ready at hand an electric torch or lighted lantern showing a white light, which shall be exhibited in sufficient time to prevent collision.

(c) A sailing vessel of 12 meters or more in length proceeding under sail when also being propelled by machinery shall exhibit forward, where it can best be seen, a conical shape, apex downward. A sailing vessel of less than 12 meters in length is not required to exhibit this shape but may do so.

(3) Vessels under oar or paddle shall when underway or anchored in a non-designated mooring area one-half hour after sunset to one-half hour before sunrise or during times of poor visibility have ready at hand an electric torch or lighted lantern showing a white light, which shall be exhibited in sufficient time to prevent collision.

(4) The display of red, green and white lights contrary to Subsection F of 18.17.2.9 NMAC or U.S. coast guard regulations is prohibited.

G. Other equipment: Persons engaged in canoeing, kayaking, paddle boarding or rubber rafting and persons using human-powered watercraft, wind sail boards, inner tubes, air mattresses, float tubes or other inflatable devices are not required to have a bailing bucket, bilge pump or any length of stout rope.

[18.17.2.9 NMAC – Rp, 18.17.2.9 NMAC, 1/1/2025]

18.17.2.10 BOAT RENTALS:

A. Records: The owner of a boat rental facility shall keep a record of the name and address of persons borrowing or hiring a vessel, the identification number thereof, the departure date and time and the expected date and time of return. The owner of a boat rental facility shall preserve the record for at least six months.

B. Equipment: Neither the owner of a boat rental facility nor an agent or employee thereof shall permit a motorboat or a borrowed or hired vessel to depart from the facility unless it is provided with the equipment required by 18.17.2.9 NMAC and the Boat Act.

[18.17.2.10 NMAC – Rp, 18.17.2.10 NMAC, 1/1/2025]

18.17.2.11 PROHIBITED OPERATIONS: The operator of a vessel operating on the waters of this state shall not engage the vessel in prohibited activities nor allow passengers to engage in activities prohibited by 18.17.2 NMAC or the Boat Act.

A. Riding the foredeck and gunwales of vessels:

(1) Except when casting off, mooring or when otherwise necessary such as for water rescue, picking up a swimmer or retrieving articles blown overboard, when a vessel is underway no vessel operator shall allow a person to ride or sit on the bow, gunwales, transom, seats on raised decks or any other place not intended for the carrying of passengers, unless the vessel is equipped with adequate guard rails designed to prevent a person from slipping under or rolling over the rail.

(2) Except when casting off, mooring or when otherwise necessary such as for water rescue, picking up a swimmer or retrieving articles blown overboard, when a vessel is underway no person shall ride or sit on the bow, gunwales, transom, seats on raised decks or any other place not intended for the carrying of passengers, unless the vessel is equipped with adequate guard rails designed to prevent a person from slipping under or rolling over the rail.

(3) Persons shall not sit on a seat back while the vessel is underway or allow their legs to hang overboard at any time.

(4) Persons shall not ride outside the railing of a pontoon boat when underway.

(5) Persons shall not ride on the elevated fishing seats of the vessel while the vessel is underway.

B. Trolling: Trolling or drift fishing is prohibited within 150 feet of a marina, boat ramp or courtesy dock.

C. Speed:

(1) Vessel operators shall not operate vessels at a speed greater than is reasonable or proper according to conditions prevailing at the time of operation.

(2) Vessel operators shall operate vessels at speeds controlled as necessary to avoid swamping or collision with any watercraft or person.

(3) Vessel operators shall observe no-wake speeds when operating within 150 feet of launch ramps, docks, mooring lines, beached or anchored vessels within 150 feet of shore, swimmers, fishermen and areas designated for "no-wake" boating. Exception to no-wake operation: under adverse weather conditions, a vessel may maintain the minimum speed necessary to maintain a safe course.

D. Overloading: No vessel operator shall carry more people on board than the number stated on a vessel's capacity plate or as computed by multiplying the vessel's length times its width and dividing by 15.

E. Pollution: No person shall deposit or discharge liquid or solid waste or other refuse into this state's waters.

F. Buoys, water marking system: No person shall anchor from, deface or relocate a buoy placed by the division or any government agency for the purpose of aiding navigation. No person shall operate a vessel in a manner that will interfere unnecessarily with the safe navigation of other vessels or anchor a vessel in the traveled portion of a channel in a way that will prevent or interfere with any other vessel passing through the same area.

G. Operation while under the influence of alcohol or controlled substances: No person shall operate a motorboat or vessel, nor use water skis, surfboard or similar device, while under the influence of alcohol or any controlled substance.

H. Age restriction: No person under the age of 13 shall operate a motorboat unless under an adult's onboard supervision.

I. Use of airborne devices prohibited: No person, while being towed by a watercraft, shall use a device, except for a parasail, for the purpose of becoming airborne over the waters of this state. No person while operating a watercraft shall tow a person using a device, except for a parasail, for the purpose of becoming airborne over the waters of this state.

J. No person shall operate a motorized vessel less than 26 feet in length without having on or affixed to their person a line or link that activates the emergency cut off switch (ECOS) while on plane or above no-wake speed. Exceptions to this requirement include when

(1) the vessel is not equipped with ECOS by the manufacturer;

(2) the engine of the vessel is three horsepower or less;

(3) while using the vessel for fishing or while docking or trailering the vessel; or

(4) when the main helm of the vessel is in an enclosed cabin.

[18.17.2.11 NMAC – Rp, 18.17.2.11 NMAC, 1/1/2025]

18.17.2.12 BOATING ACCIDENTS:

A. The operator or legal representative of a vessel involved in a collision, accident or other casualty on a water of this state shall:

(1) report the collision, accident or other casualty immediately to the local law enforcement agency; and

(2) file a boating accident report within 48 hours with the division if the collision, accident or other casualty resulted in a death, injury requiring more than standard first aid or property damage in excess of $100; forms are available at offices of state parks with lakes; reports shall be sent to and forms are also available at: State Parks Division; 1220 South Saint Francis Drive, Santa Fe, New Mexico 87505; (505) 476-3355.

B. No person shall knowingly make false claims or statements when reporting a collision, accident or casualty.

[18.17.2.12 NMAC – Rp, 18.17.2.12 NMAC, 1/1/2025]

18.17.2.13 WATER SKIING: Water skiing is permitted on the waters of this state; however, in the interest of public safety, the director or his designee may designate certain areas as closed to such activity and prohibit entry into these areas for water skiing.

A. Prohibited skiing activities:

(1) Water skiing is prohibited within 150 feet of a public dock (other than a ski dock), mooring line, launching ramp, boat, fisherman, swimmer or a person not also engaged in water skiing.

(2) No person shall intentionally obstruct or interfere with water skiers engaged in waterskiing.

(3) The use of personal watercraft such as jet skis, sea-doos, wave runners and similar devices to tow water skiers, surfboards, tubes or similar devices is prohibited except as provided in Paragraph (2) of Subsection B of 18.17.2.13 NMAC.

B. Skiing special requirements:

(1) A person in the towing vessel shall raise an international fluorescent orange or a red warning flag whenever a person on water skis or other water device has fallen, dropped off or is starting, to warn other vessels away from the area. The flag shall be a minimum of 12 inches by 12 inches and displayed high enough to be visible 360 degrees around the vessel without obstruction.

(2) No person shall pull a water skier with a personal watercraft unless:

(a) water skiing laws and rules are complied with;

(b) the personal watercraft pulling the skier has manufacturer recommended seating for at least three people;

(c) there is a vacant seat on the pulling vessel for the skier; and

(d) the personal watercraft has an observer on board in addition to the operator.

[18.17.2.13 NMAC – Rp, 18.17.2.13 NMAC, 1/1/2025]

18.17.2.14 SPECIAL REGULATIONS:

A. Weather:

(1) If at any time the superintendent determines that the weather or the condition of a lake is dangerous for boats, the superintendent may prohibit the launching or use of boats for an indefinite period of time upon the posting of appropriate notice.

(2) Boaters shall observe small craft weather warnings and seek shelter ashore when flags or lights have been activated to indicate adverse weather conditions.

B. Anchoring and mooring:

(1) Vessels when not in use shall be firmly anchored, moored or otherwise secured so as to prohibit drifting or otherwise damaging another's property. No person shall moor or anchor a vessel within 150 feet of a marina, boat ramp or courtesy dock.

(2) Private docks are prohibited except as provided in 18.17.3 NMAC. Private buoys and the mooring of houseboats are prohibited unless authorized by the director. Persons may anchor vessels overnight provided it does not impede or present a hazard to

navigation. Overnight anchoring of vessels within a state park is subject to overnight camping permits and fees, unless the person has paid camping fees for towing vehicle, except for vessels moored at concession operated facilities such as marinas or buoy lines. Persons may not leave anchored vessels vacant for more than 24 hours without the superintendent's permission unless moored at an authorized marina or buoy line.

(3) Courtesy docks are provided for the purpose of loading and unloading vessels. No person shall leave a vessel moored at a courtesy dock for longer than 10 minutes.

C. Launching: Boaters using launching areas or launching ramps on waters of this state shall be prepared to launch or load their vessels promptly without undue delay to others. After the vessel is launched, the towing vehicle shall be immediately driven well away from the launching area and parked in a designated location if such is provided.

[18.17.2.14 NMAC – Rp, 18.17.2.14 NMAC, 1/1/2025]

18.17.2.15 TRAFFIC CONTROL: When a person operating a vessel meets, overtakes or crosses another vessel's course, the operator shall take the appropriate action.

A. Meeting: When two vessels approach each other head-on or nearly so, each vessel shall steer to the starboard (right) so as to pass port (left) side to port side.

B. Passing on parallel courses: When the courses of two vessels approaching one another are so far on the starboard side of each other as not to be meeting head-on, the vessels shall pass on the starboard side of each other.

C. Overtaking: When one vessel is overtaking another, the vessel overtaking shall keep clear of the vessel being overtaken.

D. Crossing: When the courses of two vessels are such that their courses, if continued unchanged, will cross, the vessel approaching from the left shall give way by altering course, slowing down, stopping or reversing.

E. Power driven vessels: A power driven vessel shall yield the right-of-way to a non-power driven vessel except when the non-power driven vessel is passing the power driven vessel from behind the power-driven vessel shall maintain course.

F. Vessel departure/ arrival: A vessel leaving a pier or dock has the right-of-way over a vessel approaching a dock.

G. Distance: Vessels shall keep 150 feet away from swimmers, water skiers, fishermen, diver flags and others not participating in the same activity.

[18.17.2.15 NMAC – Rp, 18.17.2.15 NMAC, 1/1/2025]

18.17.2.16 RESTRICTED OPERATION ON STATE WATERS: Limits to the size, type and operation of vessels on waters within the state are provided below. Officials of the division and other state and federal agencies authorized by the director or by law and who are on official duty are exempt from 18.17.2.16 NMAC while operating in an emergency condition.

A. Bottomless lakes: Only paddle craft, vessels under oar and float tubes are permitted.

B. Clayton lake: Motorized boating activity is limited to no-wake operation only.

C. Cochiti lake: Motorized boating activity is limited to no-wake operation only.

D. Fenton lake: Only paddle craft, vessels under oar and float tubes are permitted.

E. Heron lake: Motorized boating activity is limited to no-wake operation only.

F. Morphy lake: Only vessels with electric motors, paddle craft, vessels under oar and float tubes are permitted.

G. San Juan river: Motorized vessels are prohibited on the San Juan river, within Navajo Lake state park. The use of non-motorized vessels on the San Juan river within Navajo Lake state park is authorized from the Texas hole day use area downstream and is limited to the purpose of fishing unless otherwise authorized by the director.

H. Santa Cruz: Motorized boating activity is limited to no-wake operation only.

I. Sugarite canyon: Only vessels with electric motors, paddle craft, vessels under oar and float tubes are permitted on lake Maloya. Only float tubes are permitted on lake Alice.

[18.17.2.16 NMAC – Rp, 18.17.2.16 NMAC, 1/1/2025]

18.17.2.17 VESSEL INSPECTIONS: Division law enforcement officials may randomly inspect vessels operating on the waters of this state to verify registration, titling and that the proper safety equipment is on board.

[18.17.2.17 NMAC – Rp, 18.17.2.17 NMAC, 1/1/2025]

18.17.2.18 TERMINATION OF VOYAGE: Division law enforcement officers, sheriffs in their respective county and members of the state police may terminate the voyage of a vessel when they determine the continued use of the vessel will create hazardous conditions that constitute a danger to the health and safety of the occupants of the vessel or others. The officer may direct the operator of the vessel to return to mooring, remove the vessel from the water or prohibit launching of the vessel until the unsafe conditions end or are corrected. Reasons for termination of voyage include

A. operating a vessel contrary to the provisions of 18.17.2.9 NMAC;

B. operating a vessel contrary to the provisions of 18.17.2.11 NMAC or otherwise operating a vessel in a reckless or negligent manner;

C. operating a vessel in hazardous weather as to create an undue risk to the life of the occupants of the vessel; or

D. any other conditions

a reasonable person would deem create a danger to the occupants of the vessel or others and only the immediate termination of the voyage would prevent serious injury or death.
[18.17.2.18 NMAC – Rp, 18.17.2.18 NMAC, 1/1/2025]

HISTORY OF 18.17.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the commission of public records, state records center:
SPRD 67-1, Rules and Regulations, filed 7/17/1967;
SPRD 68-1, New Mexico Pleasure Boating Requirements and State Park Regulations, filed 10/17/1968;
SPRD 69-1, New Mexico Pleasure Boating Requirements and State Park Regulations, filed 9/11/1969;
SPRD 71-1, New Mexico Pleasure Boating Requirements and State Park Regulations, filed 11/10/1971;
SPRD 72-1, New Mexico Pleasure Boating Requirements and State Park Regulations, filed 6/5/1972;
SPRD 73-3, New Mexico Pleasure Boating Requirements and State Park Regulations, filed 9/14/1973;
SPRD 74-1, New Mexico Pleasure Boating Requirements and State Park Regulations, filed 2/19/1974;
SPRD 75-1, New Mexico State Park and Recreation Commission Regulations, New Mexico Boating Law, 1975 Edition, filed 2/24/1975;
SPRD 77-1, New Mexico State Park and Recreation Commission Regulations, New Mexico Boating Law, 1977 Edition, filed 4/15/1977;
SPRD 79-1, New Mexico Park Regulations and Boating Laws, filed 7/31/1979;
SPRD 82-1, New Mexico State Park Regulations and Boating Laws, Revised in 1981, filed 5/1719/82;
SPRD 87-1, New Mexico State Park Regulations and Boating Laws, Revised in 1987, filed 5/6/1987;
EMNRD PRD 87-3, Rules Governing Motorboat Registration and Numbering, Boat Titling and Excise Tax Collections, Security Participation under the Boat Act, file 8/6/1987;
EMNRD PRD 89-1, Boating Act Regulations, filed 12/21/1989;
EMNRD PRD 92-1, Boating Act Regulations, filed 5/20/1992.

History of Repealed Material:
[**RESERVED**]

Other History:
EMNRD PRD 92-1, Boating Act Regulations (filed 5/20/1992)), was renumbered, reformatted, amended and replaced by 18 NMAC 17.2, Boating Operations and Safety, effective 12/31/1996.
18 NMAC 17.2, Boating Operations and Safety (filed 12/17/1996), was renumbered, reformatted, amended and replaced by 18.17.2.11 NMAC, Boating Operations and Safety, in an emergency rulemaking effective 9/15/2006.
18.17.2 NMAC – Boating Operations and Safety, filed 12/17/1996, was repealed and replaced by 18.17.2 NMAC – Boating Operations and Safety, effective 1/1/2025.

ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT
STATE PARKS DIVISION

TITLE 19 NATURAL RESOURCES AND WILDLIFE
CHAPTER 5 STATE PARKS AND RECREATION
PART 1 GENERAL PROVISIONS

19.5.1.1 ISSUING AGENCY: Energy, Minerals and Natural Resources Department, State Parks Division.
[19.5.1.1 NMAC - Rp, 19.5.1.1 NMAC, 01/01/2025]

19.5.1.2 SCOPE: 19.5.1 NMAC applies to persons using the New Mexico state parks system.
[19.5.1.2 NMAC - Rp, 19.5.1.2 NMAC, 01/01/2025]

19.5.1.3 STATUTORY AUTHORITY: 19.5.1 NMAC is authorized pursuant to Subsection E of Section 9-1-5 NMSA 1978 and Section 16-2-2 *et seq*. NMSA 1978.
[19.5.1.3 NMAC - Rp, 19.5.1.3 NMAC, 01/01/2025]

19.5.1.4 DURATION: Permanent.
[19.5.1.4 NMAC – Rp, 19.5.1.4 NMAC, 01/01/2025]

19.5.1.5 EFFECTIVE DATE: January 1, 2025, unless a later date is cited at the end of a section.
[19.5.1.5 NMAC – Rp, 19.5.1.5 NMAC, 01/01/2025]

19.5.1.6 OBJECTIVE: 19.5.1 NMAC's objective is to identify general provisions and definitions, which apply to parts in Title 19, Chapter 5.
[19.5.1.6 NMAC – Rp, 19.5.1.6 NMAC, 01/01/2025]

19.5.1.7 DEFINITIONS:
A. "Authorized areas" means locations, places, sites, regions, zones or spaces identified by the director or, for purposes of hunting or fishing, the state game commission. These areas may be defined with signs or other appropriate proclamation or means. For purposes of bowfishing, authorized areas include all parks where fishing is allowed.
B. "Boating and rafting excursions" means a guiding service for boating or rafting trips offered to the general public.
C. "Capital improvement" means a construction project by a concessionaire to the concession premises that is not maintenance or repair and that costs at least $1,000.
D. "Commercial activity" means for-profit sales or services but does not include the operation of vending machines unless the vending machine is operated as part of a larger concession operation.
E. "Commercial charter bus" means a bus transporting a group of persons who pursuant to a common purpose, and under a single contract at a fixed price, have acquired the exclusive use of a bus to travel together under an itinerary.

F. "Commercial filming" means the use of motion picture, videotaping, sound recording or other moving image or audio recording equipment that involves the advertisement of an event, product or service; or the creation of a product for sale including film, videotape, television broadcast or documentary of participants in commercial sporting or recreation events for the purpose of generating income.

G. "Commercial photography" means still images taken with a camera that the photographer intends to sell.

H. "Concession" means commercial activity conducted within a park the department has authorized in writing.

I. "Concessionaire" means the owner or operator of a concession who operates pursuant to a department-issued concession contract.

J. "Concessions administrator" means a division employee who maintains records and documentation concerning concession contracts and concession permits.

K. "Concession contract" means an agreement between the department and a person, or business entity, which allows the concessionaire to provide services, merchandise, accommodations or facilities within a park. The concessionaire may or may not occupy a permanent structure or location within the park. The concession contract's term shall not exceed 30 years pursuant to Section 16-2-9 NMSA 1978.

L. "Concession permit" means a permit the department issues to a person or business entity to provide commercial activities, including services or goods in a park for a period of up to one year. The fee for a concession permit is established in 19.5.6 NMAC. Services the division may authorize under a concession permit include guiding and outfitting services for fishing, boating and rafting excursions; educational and park resource protection services; and other services or goods, including commercial services, that enhance visitors' experience and enjoyment, such as sales of firewood, propane, ice, food or refreshments.

M. "Concession permittee" means the holder of a department-issued concession permit.

N. "Cultural property" means a structure, place, site or object having historic, archaeological, scientific, architectural or other cultural significance.

O. "Department" means the energy, minerals and natural resources department.

P. "Director" means the director of the energy, minerals and natural resources department, state parks division.

Q. "Director designee" means persons the director appoints including deputy directors, bureau chiefs, regional managers and park superintendents.

R. "Division" means the energy, minerals and natural resources department, state parks division.

S. "Flotation assist device" means a wet suit or wearable flotation device in good condition capable of providing flotation to the wearer on the water's surface.

T. "Geocaching" means an outdoor treasure-hunting activity in which the participants use a global positioning system receiver or other navigational means to hide or find containers called "geocaches" or "caches".

U. "Gross receipts from sales and services" means the total amount of receipts from sales and services.

V. "Guide" means an individual or an employee of an outfitter who is hired to escort or accompany clients in fishing, rafting or boating.

W. "Letter boxing" means an outdoor hobby that combines elements of orienteering, art and puzzle solving. Letter boxers hide small, weatherproof boxes in publicly accessible places and distribute clues to finding the boxes in printed catalogs, on websites or by word of mouth. The activity is characterized by the boxes containing a logbook and a rubber stamp. Letter boxers stamp the box's logbook with personal rubber stamps and use the box's stamp to imprint their personal logbooks as proof they found the box.

X. "Net receipts from sales and services" means the total amount of receipts from sales and services, less the amount of gross receipts taxes.

Y. "Off highway motor vehicle" means a motor vehicle designed by the manufacturer for operation exclusively off the highway or road and includes:

(1) "all-terrain vehicle", which means a motor vehicle 50 inches or less in width, having an unladen dry weight of 1,000 pounds or less, traveling on three or more low-pressure tires and having a seat designed to be straddled by the operator and handlebar-type steering control;

(2) "off-highway motorcycle", which means a motor vehicle traveling on not more than two tires and having a seat designed to be straddled by the operator and has handlebar-type steering control;

(3) "snowmobile", which means a motor vehicle designed for travel on snow or ice and steered and supported in whole or part by skis, belts, cleats, runners or low-pressure tires;

(4) "recreational off-highway vehicle", which means a motor vehicle designed for travel on four or more non-highway tires, for recreational use by one or more persons, and having:

(a) a steering wheel for steering control;

(b) non-straddle seating;

(c) maximum speed capability greater than 35 miles per hour;

(d) gross vehicle weight rating no greater than 1,750 pounds;

(e) less than 80 inches in overall width, exclusive of accessories;

(f) engine displacement of less than 1,000 cubic centimeters; and

(g) identification by means of a 17-character vehicle identification number; or

(5) by rule of the department of game and fish, any other vehicles that may enter the market that fit the general profile of vehicles operated off the highway for recreational purposes.

Z. "Other power-driven mobility device" means any mobility device powered by batteries, fuel or other engines – whether or not designed primarily for use by individuals with mobility disabilities – that is used by individuals with mobility disabilities for the purpose of locomotion including golf cars, electronic personal assistance mobility devices, such as the Segway® PT, or any mobility device designed to operate in areas without defined pedestrian routes, but that is not a wheelchair.

AA. "Outfitter" means a person or company who employs guides.

BB. "Park" means an area designated as a state park within the state parks system and that the division manages or owns.

CC. "Park" or **"parking"** means the leaving of a vehicle, camping unit or trailer, whether occupied or not, in a location, other than when engaged in loading or unloading.

DD. "Park management and development plan" means a plan used as a guide for expansion, services, programs and development for the park.

EE. "Park support group" means an organization as defined in Section 6-5A-1 NMSA 1978, or an organized group of individuals that volunteers time, services or funds to promote and support the division or an individual park and whose principal purpose as authorized by the division is to complement, contribute to and support, aid the function of or forward the division's or park's purposes.

FF. "Person" means an individual, partnership, firm, corporation, association, joint venture or other entity.

GG. "Personal flotation device" means a United States coast guard approved life preserver, buoyant vest, hybrid device, ring buoy or buoyant cushion.

HH. "Rally" means a parking area or facility designated for group functions.

II. "Receipts" means consideration in money and in trade received from sales and charges for services.

JJ. "Regional manager" means a division employee responsible for several parks within a region.

KK. "Resident" means an individual with a valid New Mexico state identification card or NM license plate on the vehicle.

LL. "Resource program" means a division employee or employees responsible for the natural and cultural resource protection program.

MM. "Sales and services" means transactions by a concessionaire, or a concessionaire's agents or employees, for which the concessionaire receives consideration in money or money's worth in connection with the concession business operated pursuant to the concession contract.

NN. "Secretary" means the secretary of the department.

OO. "Special event facility" means an entire building or structure such as a visitor center, lodge, pavilion or group shelter, or an area designated by the superintendent.

PP. "Special use permit" means a permit the division has issued to a person for a non-commercial activity or event in a park.

QQ. "State parks system" means land and water in a park.

RR. "Superintendent" means a division employee who is in charge of a specific park; which includes a park superintendent or park manager.

SS. "Vehicle" means an automobile, car, van, sport-utility truck, pickup truck, motorcycle, wagon, buggy or similar device that is used or may be used to transport persons or property on a highway, except devices moved exclusively by human power.

TT. "Vending machine" means a coin-operated beverage, snack or service machine subject to division approval.

UU. "Visitor" means a person who reserves park facilities or enters a park. This definition does not include department employees who are on duty, concessionaires or their employees operating their concession or on duty employees of an entity that owns the property where the park is located.

VV. "Wheelchair" means a manually operated or power-driven device designed primarily for use by an individual with a mobility disability for the main purpose of indoor or both indoor and outdoor locomotion.

WW. "Working days" means Monday through Friday, excluding state holidays.

[19.5.1.7 NMAC – Rp, 19.5.1.7 NMAC, 01/01/2025]

History of 19.5.1 NMAC:

Pre NMAC History: The material in this part was derived from that previously filed with the commission of public records - state records center and archives.

SPRD 67-1, Rules and Regulations, 07/17/1967;

SPRD 68-1, New Mexico Pleasure Boating Requirements and State Park Regulations, 10/17/1968;

SPRD 69-1, New Mexico Pleasure Boating Requirements and State Park Regulations, 09/11/1969;

SPRD 71-1, New Mexico Pleasure Boating Requirements and State Park Regulations, 11/10/1971;

SPRD 72-1, New Mexico Pleasure Boating Requirements and State Park Regulations, 06/05/1972;

SPRD 73-3, New Mexico Pleasure Boating Requirements and State Park Regulations, 09/14/1973;

SPRD 74-1, New Mexico Pleasure

Boating Requirements and State Park Regulations, 02/19/1974;
SPRD 75-1, New Mexico State Park and Recreation Commission Regulations, New Mexico Boating Law, 1975 Edition, 02/24/1975;
SPRD 77-1, New Mexico State Park and Recreation Commission Regulations, New Mexico Boating Law, 1977 Edition, 04/15/1977;
SPRD 79-1, New Mexico Park Regulations and Boating Laws, 07/31/1979;
SPRD 82-1, New Mexico Park Regulations and Boating Laws Revised in 1981, 05/17/1982;
SPRD 87-1, New Mexico State Park Regulations and Boating Laws, Revised in 1987, 05/06/1987;
EMNRD PRD 87-3, Rules Governing Motorboat Registration and Numbering, Boat Titling and Excise Tax Collections, Security Participation under The Boat Act, 08/06/1987;
EMNRD PRD 89-1, Boat Act Regulations, 12/21/1989;
EMNRD PRD 89-2, New Mexico State Park Regulations, 12/21/1989;
EMNRD PRD 92.1, Boat Act Regulations, 05/20/1992.

History of Repealed Material:
[RESERVED]

Other History:
Those portions of EMNRD PRD 89-2, New Mexico State Park Regulations, filed 12/21/1989 and EMNRD PRD 92.1, Boat Act Regulations, filed 05/20/1992 were renumbered, reformatted and replaced by 19 NMAC 5.1, General Provisions, filed 12/17/1996.
19 NMAC 5.1, General Provisions, filed 12/17/1996 renumbered, reformatted, amended and replaced by 19.5.1 NMAC, General Provisions; effective 12/31/2002.
19.5.1 NMAC, General Provisions; filed 12/31/2002, was repealed and replaced by 19.5.1 NMAC, General Provisions; effective 01/01/2025.

ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT
STATE PARKS DIVISION

This is an amendment to 19.5.2 NMAC, Sections 10 through 14, 16, 21, 27, 32, through 35, 38, 39 and 42, effective 1/1/2025.

19.5.2.10 HOURS: The director or the [~~director~~] director's designee establishes opening and closing times for every area and facility of the state parks system. Hours are posted at the established park entrances, offices or pay stations. [19.5.2.10 NMAC - Rp, 19.5.2.10 NMAC, 1/1/2008; A, 1/1/2025]

19.5.2.11 DAY USE:

A. Day use of a park area is from 6:00 a.m. to 9:00 p.m. unless the superintendent posts different hours or extends hours for special programs or events. Visitors shall pay required day-use fees upon entering the park. See 19.5.6 NMAC.

B. The division may designate areas solely for day use to exclude camping.

C. Visitors shall always maintain sites in parks in a clean and sanitary condition [~~at all times~~].

D. Visitors shall clean the site and dispose of trash and litter in appropriate waste receptacles. [19.5.2.11 NMAC - Rp, 19.5.2.11 NMAC, 1/1/2008; A, 1/1/2013; A, 1/1/2025]

19.5.2.12 CAMPING:

A. Visitors may camp in parks in designated areas, provided [~~that~~] they obtain a valid camping permit. Visitors shall obtain permits upon entry by paying appropriate fees. See 19.5.6 NMAC. Use of park properties and facilities between the hours of 9:00 p.m. and 6:00 a.m., or as posted by the superintendent, is camping. Check out time, the time the campsite is to be vacated, is 2:00 p.m. unless otherwise posted; however, the camping permit allows day use of the park until 9:00 p.m. or as posted by the superintendent, on the day the camping permit expires. Camping is not available at Cerrillos Hills state park, Living Desert Zoo and Gardens state park, Rio Grande Nature Center state park, Mesilla Valley state park or Smokey Bear historical park.

B. Campers shall not leave unoccupied any type of vehicle, motorized camper, trailer, tent or other sleeping unit or facility or otherwise leave a campsite unoccupied for more than 24 hours without the superintendent's prior approval. Unoccupied means the camper is not present at the campsite for more than 24 hours.

C. Campers shall always maintain campsites in a clean and sanitary condition [~~at all times~~]. Campers shall clean campsites and place litter only in appropriate disposal containers.

D. Campers in areas or parks designated and posted by the superintendent as pack-in, pack-out, shall carry out supplies and solid waste or other refuse, including human bioproducts, and properly dispose of these items in appropriate waste receptacles outside of the designated area or park.

E. From October 1 through April 30 [~~Campers~~] campers may reside in a park for a maximum of 14 calendar days during any 20-calendar day period unless the director extends, decreases or waives this limit. From May 1 through September 30 campers may reside in a park for a maximum of seven calendar days during any 20-calendar day period unless the director extends, decreases or waives this limit. Campers shall completely remove camping equipment and gear from the park [~~for six calendar days during the 20-calendar day period~~] after reaching the maximum stay limit.

F. The division shall charge fees according to the facilities provided at each campsite, as provided in 19.5.6 NMAC, regardless of whether the camper uses the facilities at the campsite. For example, camping at a site with electricity requires payment of the fee

for a developed site with electrical hookup even if the camper uses no electricity.

G. Vehicles in a park between the hours of 9:00 p.m. and 6:00 a.m., or as posted by the superintendent, are individually subject to the appropriate camping fees. The division considers motor homes towing a vehicle or vehicles towing a camper a single vehicle for 19.5.2.12 NMAC's purposes.

H. The division may require visitors to pay fees for their entire stay in advance (rather than daily) for weekends, holidays or special events.

I. Anchoring a boat or vessel overnight within a park constitutes camping and requires a valid camping permit for the anchored boat or vessel unless the visitor has paid camping fees for the towing vehicle.

(1) Visitors may not leave anchored boats or vessels vacant for more than 24 hours without the superintendent's permission. From October 1 through April 30 [~~Anchored~~] anchored boats or vessels may remain within a park for a maximum of 14 calendar days during any 20-calendar day period unless the director extends, decreases or waives this limit. From May 1 through September 30 [~~Anchored~~] anchored boats or vessels may remain within a park for a maximum of seven calendar days during any 20-calendar day period unless the director extends, decreases or waives this limit. Visitors shall completely remove boats or vessels from the park [~~for six calendar days during the 20 calendar-day period~~] after reaching the maximum stay limit.

(2) Subsection I of 19.5.2.12 NMAC does not apply to boats or vessels only while they are moored overnight at concession operated facilities such as marinas or buoy lines. Boats or vessels are subject to division camping permits and camping fees when moored overnight at any other location in the park. Time limits do not apply while boats or vessels are moored at the concession facilities.

J. Reserved campsites shall become available to other visitors if the visitor holding the reservation does not occupy the reserved site or contact the reservations contractor or the park by [~~4~~] 4:00 p.m. the day after the scheduled arrival date. At that time the site will be available to other visitors and reservations. The visitor holding the reservation who failed to file a cancellation is not eligible for a refund.

[19.5.2.12 NMAC - Rp, 19.5.2.12 NMAC, 1/1/2008; A, 1/1/2013; A, 5/15/2018; A, 1/1/2025]

19.5.2.13 USE OF FACILITIES:

A. Facilities are available on a first come, first served basis except at parks where the division has established a reservation program and a visitor has reserved the facility. Campers shall not save or reserve camping spaces for other individuals even by purchasing additional permits.

B. Visitors using a park facility shall keep it in a clean and sanitary manner and shall leave it in a clean and sanitary condition.

C. Glass containers are prohibited outside vehicles, motor homes, campers, trailers and tents within the state parks system except on established commercial premises.

D. The division has developed and designated special accessible facilities for the use of individuals with disabilities. These facilities are marked with standard ADA signage. Individuals with disabilities shall have preferential use of these facilities over other persons.

E. Visitors shall not remove water from the park for use outside the park or deposit trash generated outside the park within a park.

F. Advance reservations are required for the use of meeting rooms. Meeting rooms are not available [~~at~~] in all parks. A person who reserves a meeting room is responsible for setting up the room, cleaning the room after use and leaving the room in the same condition it was in before use. See 19.5.6 NMAC for meeting room fees.

G. The director may designate areas within the state parks system including campsites, group shelters, group areas, cabins, yurts and lodges for use by reservation.

H. Advance reservations are required for the use of group shelters, group areas or reservation campsites. Visitors shall pay the appropriate day use or camping fees in addition to the fees for use of the facility or area. If visitors make reservations through the division's reservation system contractor, visitors shall pay the reservation processing and cancellation fees the contractor charges. The division may accept annual permits at reservation campsites if posted. See 19.5.6 NMAC for group shelter fees.

I. The superintendent may restrict the number or size of tents, shade or screen shelters occupying a campsite or day use site by posting the restriction or restrictions in the affected area or areas.

[19.5.2.13 NMAC - Rp, 19.5.2.13 NMAC, 1/1/2008; A, 12/30/2010; A, 1/1/2013; A, 5/15/2018; A, 1/1/2025]

19.5.2.14 PARKING:

A. Visitors shall park vehicles, camping units or trailers only in established parking areas or parking turnouts where provided. Visitors shall not park any vehicle, camping unit or trailer in a manner that blocks access, restricts traffic or inhibits the free movement of other vehicles, persons or wheelchairs. Visitors shall not leave a trailer, boat or vessel that is not attached to a vehicle in parking areas or parking turnouts for a period of more than [~~72~~] 24 hours without prior approval of the superintendent. At the superintendent's discretion, the division may remove vehicles so parked at the owner's expense.

B. Visitors shall not park a vehicle, camping unit or trailer in a designated disabled parking space unless the visitor's vehicle has registration plates or a state-issued placard indicating disability.

C. The superintendent may restrict the number or size of vehicles, camping units or trailers occupying a campsite, day use site or parking area by posting the restriction or restrictions in the affected area or areas.

[19.5.2.14 NMAC - Rp, 19.5.2.14 NMAC, 1/1/2008; A, 1/1/2013; A, 1/1/2025]

19.5.2.16 OFF-HIGHWAY MOTOR VEHICLES AND GOLF CARS:

A. Visitors shall not operate off-highway motor vehicles or golf cars in the state parks system, [~~with the exception of~~] except for persons with mobility disabilities as provided in Subsection D of 19.5.2.16 NMAC [~~or as provided in Subsection F of 19.5.2.16 NMAC for ice fishing~~].

B. [~~State park officials may use off-highway motor vehicles or golf cars for park operations and maintenance.~~] Off-highway motor vehicles and golf cars may be used for official purposes including:

(1) state park officials may use off-highway motor vehicles or golf cars for park operations and maintenance;

(2) government agencies or government officials or employees, including law enforcement and emergency service personnel, may use off-highway motor vehicles or golf cars while performing official duties in state parks (official duties do not include activities that do not have to occur in a park such as conferences, retreats, or training).

C. The park superintendent may approve the use of golf cars or off-highway motor vehicles by concessionaires within certain areas of a park for concession operations and maintenance.

D. Other power-driven mobility devices may only be used by visitors with mobility disabilities on established roads, pathways, trails and other areas open to pedestrian use. The use of other power-driven mobility devices is subject to more stringent laws or rules or regulations of a landowner (*e.g.* United States department of the interior, bureau of reclamation; New Mexico department of game and fish; United States army corps of engineers, New Mexico state land office, etc.) from which the division leases the land or reservoir. Visitors and state park officials shall comply with laws or regulations or rules of the landowner (*e.g.* United States department of the interior, bureau of reclamation) where applicable. Visitors shall consult park information provided at the park office and on the division's official website to determine limitations on park pathways, trails and other areas open to pedestrian use. To ensure protection of park resources, visitor safety and enjoyment:

(1) only other power-driven mobility devices not exceeding 36 inches in width and 62 inches in length are permitted on park pathways, trails and other areas open to pedestrian use;

(2) certain park pathways, trails and other areas open to pedestrian use may have other size limitations, or use of other power-driven mobility devices on certain park pathways, trails and other areas open to pedestrian use may be prohibited, as designated at the park office and on the division's official website;

(3) internal combustion engine devices are prohibited on park pathways, trails and other areas open to pedestrian use;

(4) maximum speed on park pathways, trails and other areas open to pedestrian use shall not exceed 10 miles per hour;

(5) the use of other power-driven mobility devices on park pathways, trails and other areas open to pedestrian use that produces noise that exceeds 96 decibels when measured using test procedures established by the society of automotive engineers pursuant to standard J1287 is prohibited.

E. Persons using an other power-driven mobility device may be required to provide verification that the mobility device is required because of the person's disability. Acceptable forms of verification are:

(1) a valid, state-issued, disability parking placard or card;

(2) other state-issued proof of disability; or

(3) in lieu of Paragraphs (1) and (2) of Subsection E of 19.5.2.16 NMAC, a person may provide a verbal representation, not contradicted by observable fact, that the other power-driven mobility device is being used for a mobility disability.

[~~**F.** Persons may use off-highway motor vehicles for ice fishing on the surface of the ice and in designated boat launch areas when the lake is open to ice fishing and designated for off-highway motor vehicle use.~~]

[19.5.2.16 NMAC - Rp, 19.5.2.16 NMAC, 1/1/2008; A, 1/1/2013; A, 5/15/2018; A, 1/1/2025]

19.5.2.21 FIREARMS AND BOWS:

A. Visitors shall not possess firearms with a cartridge in any portion of the [~~mechanisam~~] mechanism except:

(1) a legally licensed hunter during a designated hunting season and within park areas designated as open to hunting for the species the hunter is licensed to hunt;

(2) on duty law enforcement officials;

(3) persons with a valid concealed handgun license issued to them pursuant to the Concealed Handgun Carry Act, Section 29-19-1 *et seq*. NMSA 1978.

(4) persons with a concealed handgun license issued to them by a state that has a valid concealed handgun reciprocity agreement with the state on New Mexico; or

(5) persons carrying a firearm in a private vehicle or other private means of conveyance, for lawful protection of the person's or another's person or property.

B. Visitors shall not discharge a firearm within a state park except:

(1) a legally licensed hunter during designated hunting season who is hunting within park areas designated as open to hunting for the species the hunter is licensed to hunt and who is more than 300 yards from a developed park area or occupied campsite;

(2) on duty law enforcement officials pursuant to their official duties; or

(3) persons with a valid concealed handgun license issued to them pursuant to the Concealed Handgun Carry Act, Section 29-19-1 *et seq*. NMSA 1978, or another state that has a valid concealed handgun reciprocity agreement with the state of New Mexico when discharged in self defense, defense of another person or defense of a dwelling or habitation.

C. Visitors shall not use or discharge arrows, bolts or air or gas fired projectiles, weapons and other devices capable of causing injury to persons or animals or damage or destruction of property in the state parks system, except:

(1) a legally licensed hunter or fisherman during a designated hunting or fishing season who is hunting or fishing within park areas designated as open to hunting or fishing for the species the hunter or fisherman is licensed to hunt or fish, or in authorized areas, and who is more than 100 yards from a developed park area or occupied campsite; or

(2) for park authorized events and activities.

D. Subsection C of 19.5.2.21 NMAC does not apply to on duty law enforcement officials acting pursuant to their official duties.

[19.5.2.21 NMAC - Rp, 19.5.2.21 NMAC, 1/1/2008; 19.5.2.21 NMAC - Rn & A, 19.5.2.20 NMAC, 1/1/2013; A, 1/1/2025]

19.5.2.25 ROCK COLLECTING:

A. Rock collecting is [~~permissable~~] permissible in areas designated by the secretary and posted at the rockhound unit of Rockhound state park.

B. Rocks removed from Rockhound state park shall be as [~~souvernirs~~] souvenirs only, not for resale, trade or commercial use.

C. Rock collecting is limited to small hand tools only. The following are prohibited: mechanical or motorized tools and equipment, tools with a handle longer than 12 inches, wheeled devices such as wheelbarrows, carts or wagons.

[19.5.2.25 NMAC - Rp, 19.5.2.23 NMAC, 1/1/2008; 19.5.2.25 NMAC - N, 1/1/2013; A, 1/1/2025]

19.5.2.27 CONDUCT:

A. Visitors are encouraged to enjoy park experiences without infringing upon other visitors' ability to enjoy the same experiences. Visitors shall not engage in threatening, abusive, boisterous, insulting or indecent language or behavior.

B. Visitors shall not solicit, gamble or illegally discriminate.

C. Visitors shall not evade, disobey or resist a state park official's lawful order.

D. Parents, guardians or other adults in charge shall exercise constant direct supervision of minor children or adults who do not possess the intelligence or awareness to recognize possible danger.

E. Law enforcement officers may forcibly eject a person who violates a state law or a department rule or a person who evades, disobeys or resists a state park official's lawful order from a park. Based on the severity of conduct or reported incident, *i.e.*, threatening or intimidating conduct toward visitors or park staff, the ejection may be permanent.

(1) Permanent ejection requires the regional manager to issue written notification to the person being permanently ejected.

(2) To request review of a permanent ejection a regional manager issues, an individual ejected from a park or parks shall submit a written request including the reasons for requesting review to the director within 15 calendar days of issuance and provide written notice to the regional manager.

(3) The regional manager and the ejected individual shall submit written statements to the director within 10 working days of the submission of the request for review.

(4) The director shall base [~~his or her~~] the director's decision on the written statements unless the ejected individual or the regional manager requests the opportunity to call witnesses or make oral arguments within 10 working days of the request for review.

(5) A request for hearing shall explain the need for any witness testimony or oral argument. If the ejected individual or regional manager asks to make oral arguments or call witnesses, the director may set a hearing to be held within 10 working days after receiving that request and provide notice of the hearing date, time and location to the regional manager and the ejected individual. Oral testimony shall be made under oath. [~~A tape~~] An audio or stenographic record shall be made of any oral argument or witness testimony.

(6) The director shall issue a written final decision, including findings of fact within 10 working days after the date for submission of written statements, or a hearing if any, and send copies to the ejected individual and the regional manager.

[19.5.2.27 NMAC - Rp, 19.5.2.25 NMAC, 1/1/2008; 19.5.2.27 NMAC - Rn & A, 19.5.2.25 NMAC, 1/1/2013; A, 1/1/2025]

19.5.2.32 FEES AND CHARGES:

A. Upon entering a park, visitors shall pay fees and charges in accordance with 19.5.6 NMAC. The visitor shall display applicable permits in accordance with instructions provided with the permit. If a visitor fails to obtain a permit, state park officials may field collect fees.

B. Fees, charges and permit display requirements do not apply to:

(1) government agencies or government officials or employees, including law enforcement and emergency service personnel, who are performing official duties (official duties do not include activities that do not have to occur in a park such as conferences, retreats or training);

(2) non-governmental emergency service personnel, such as private ambulance companies, who are performing their official duties;

(3) persons traveling nonstop through a park on a state or federal highway, county road, federal road or municipal road or street;

(4) on duty news media personnel who are reporting on events or activities within a park and are only in the park to report on those events or activities; or

(5) individuals or groups who are entering the park to provide volunteer services and have signed a volunteer agreement with the division or have [~~made arrangements~~] arranged with the division to provide volunteer services.

C. Fees and charges do not apply to:

(1) division contractors, suppliers or agents or other persons providing services to a park who are not using the park or its facilities for purposes other than providing services to the park;

(2) concessionaires, concession permittees or their employees or commercial contractors, suppliers and agents who are only traveling to and from the concession and are not using the park or its facilities for personal use;

(3) persons needing to pass through a park to access private property who are only passing through the park and are not using the park or its facilities;

(4) park support group members or volunteers who have a park pass issued pursuant to Subsection D of 19.5.2.36 NMAC; or

[~~**(5)** persons who are only entering the Conchas Lake state park to access the concessionaire store, restaurant or bar at the north area of Conchas Lake state park and are not using the park or its facilities, provided they park in the designated concessionaire parking area at the north area~~].

D. Visitors not subject to Subsection B of 19.5.2.32 NMAC shall display permits at all times inside a park.

E. The superintendent or director may waive or reduce park fees for primary or secondary school groups, [~~or~~] college or university groups, [~~that are involved with a division educational program or have made arrangements with the division to conduct research within a park~~] or other organized youth groups or for governmental entities holding such activities as trainings or other educational activities or projects, retreats or conferences at a park.

F. State park officials may issue rain checks for unused, prepaid daily camping activities or the cancellation of a group shelter reservation.

G. The division or its contractors may charge fees in addition to the appropriate use fee for reservation processing and cancellation. The contractor or state park officials shall collect the reservation fee for those park sites where the division has established a reservation program. See 19.5.6 NMAC. Visitors shall pay the reservation fee in advance with applicable fees for facilities, sites, day use, camping, electricity or other service for the total reservation period.

H. In addition to the appropriate use fees, the division may charge additional fees for special events such as concerts, festivals, etc. The additional fees shall not exceed the value of admission to the special events.

[19.5.2.32 NMAC - N, 1/1/2008; 19.5.2.32 NMAC - Rn & A, 19.5.2.30 NMAC, 1/1/2013; A, 5/15/2018; A, 1/1/2025]

19.5.2.33 PERMITS AND CONCESSIONS: Concession-operated [~~camp grounds~~] campgrounds do not accept division-issued permits.

[19.5.2.33 NMAC - Rp, 19.5.2.28 NMAC, 1/1/2008; A, 12/30/2010; 19.5.2.33 NMAC - Rn, 19.5.2.31 NMAC, 1/1/2013; A, 1/1/2025]

19.5.2.34 DAY USE AND CAMPING PERMITS:

A. Day use permits.

(1) Day use permits authorize visitors to use park facilities that do not require other fees, such as meeting rooms or group shelters, from 6:00 a.m. to 9:00 p.m.; unless the superintendent has posted different hours.

(2) When purchasing the day use permit visitors shall comply with the instructions on the permit and provide, as requested, their name, address and vehicle license number as well as the date of purchase and the amount enclosed and, if applicable, their site number. Visitors shall also indicate [~~that they are only paying for day use~~] they are visiting the park for day use.

(3) New Mexico residents are exempt from purchasing day use permits from October 1 through April 30 annually.

B. Camping permits. Visitors shall purchase camping permits to camp in a park.

(1) Subject to the availability of a campsite, camping permits authorize visitors to camp in a park.

(2) When purchasing the camping permit visitors shall comply with the instructions on the permit and provide, as requested, their name, address and vehicle license number as well as their site number, the date of purchase, the amount enclosed and length of stay and, if applicable, their annual permit number. Visitors shall also indicate [~~that~~] they are camping.

[19.5.2.34 NMAC - N, 1/1/2008; 19.5.2.34 NMAC - Rn, 19.5.2.32 NMAC, 1/1/2013; A, 1/1/2025]

19.5.2.35 ANNUAL PERMITS AND PASSES:

A. Annual day use passes.

(1) Annual day use passes authorize the vehicle owner or individual to access and use the park at no additional charge during the times indicated in 19.5.2.11 NMAC. Visitors may use annual day use passes at all parks, except at the Living Desert Zoo and Gardens state park and Smokey Bear historical park.

(2) When purchasing an annual day use pass visitors shall comply with the instructions on the pass and provide their name and address.

(3) The division does not issue extra vehicle passes for annual day use passes.

B. Annual camping permits.

(1) Annual camping permits authorize the vehicle owner or individual to access and use the park at no additional charge except for utility hookups during the times indicated in 19.5.2.12 NMAC. The annual camping permit allows the visitor one sleeping unit. A motor home towing a vehicle or a vehicle towing a camping trailer is considered a sleeping unit. The visitor shall pay the per night camping fee for additional vehicles.

(2) Annual camping permits are available for:

(a) New Mexico residents as documented with a current New Mexico driver's license or other state of New Mexico issued photo identification;

(b) New Mexico residents 62 years of age or older as documented with a current New Mexico driver's license or other state of New Mexico issued photo identification;

(c) New Mexico residents with disabilities who present a New Mexico handicap motor vehicle license plate issued to them; a parking placard for mobility impaired individuals with a placard holder identification card issued to them by the taxation and revenue department, motor vehicle division if the placard was issued before June 4, 2008; a parking placard for mobility impaired individuals with the photograph of the placard holder issued to them by the taxation and revenue department, motor vehicle division if the placard was issued on June 4, 2008 or after; a New Mexico department of game and fish lifetime hunting and fishing card containing their name; a written determination from the United States social security administration finding that they are currently eligibile for social security disability benefits or supplemental security income disability benefits; or a photocopy of the award letter the United States department of veterans affairs issues indicating they have a one hundred percent service-connected disability; [~~and~~]

(d) A New Mexico resident who is active-duty military or an honorably discharged veteran of the United States military as defined by the New Mexico department of veterans' services. Orders or other documentation (excluding military ID cards) of current active-duty service must be presented to purchase an active-duty military pass. The applicant's DD-214 must be presented to purchase a veteran pass.

[~~**(d)**~~] **(e)** all-out-of-state-residents.

(3) When purchasing an annual camping permit, visitors shall comply with the instructions on the permit and provide their name; address; if applicable, proof of age or residency; and the license plate number of the vehicle for which the visitor is purchasing the permit.

(4) Visitors may use annual camping permits at all parks, except at the Living Desert Zoo and Gardens state park and Smokey Bear historical park.

(5) Annual camping permits are authorized for use by the person the permit is issued to as indicated on the permit receipt and are non-transferrable.

C. Annual day use passes and annual camping permits [~~expire 12 months after the date the division issues them~~] are valid from January 1 through December 31 annually. Annual day use passes and annual camping permits for the next calendar year may be purchased beginning July 1 each year. The division shall not make refunds or prorations for permits or passes that remain in effect for less than 12 months.

D. Visitors may obtain replacement annual camping permits and stickers by submitting a signed affidavit describing the facts of the purchase and the permit's loss or destruction and [~~if available,~~] the original permit or proof of purchase. The division shall not issue replacement annual camping permits without proof of purchase. The division does not issue replacements for annual day use passes.

E. The division may sell gift certificates for annual day use passes and annual camping permits.

[19.5.2.35 NMAC - N, 1/1/2008; 19.5.2.35 NMAC - Rn & A, 19.5.2.33 NMAC, 1/1/2013; A, 1/1/2025]

19.5.2.38 FOSTER FAMILIES: Foster parents and children in their custody, young adults enrolled in the fostering connections program and children who are in custody of the children, youth and families department or in tribal custody, who are New Mexico residents are entitled to free day use of parks and a camping pass for up to three consecutive nights of overnight access to a state park. To obtain a free annual day use pass for entry to parks or a free camping pass for up to three consecutive nights of overnight access to a state park the foster parent shall present a current New Mexico driver's license or other state of New Mexico issued photo identification and a current New Mexico children, youth and families department foster parent certification card to park staff.

[19.5.2.38 NMAC – N, 6/25/2019; A, 1/1/2025]

19.5.2.39 PARK PASSES:

A. Concessionaires. The director or director designee (see

Subsection Q of 19.5.7 NMAC) may issue park passes to concessionaires, concession permittees or their employees or commercial contractors, suppliers and agents for access to and from the concession. Concessionaires, concession permittees or their employees or commercial contractors, suppliers and agents using the park, lake or facilities away from the concession premise shall pay the appropriate fees.

B. Contractors. The director or director designee (see Subsection Q of 19.5.1.7 NMAC) may issue park passes to division contractors, suppliers or agents or other persons providing services to a park for access to the park. Division contractors, suppliers or agents or other persons providing services to a park using the park or its facilities for purposes other than providing services to a park shall pay the appropriate fees.

C. Access to private property. The director or director designee may issue park passes to persons needing to pass through a park to access private property. Persons with such park passes shall only use the park passes to travel through the park. If they use the park or its facilities they shall pay the appropriate fees.

D. Park support groups and volunteers. The director or director designee may issue park passes to individuals who are members of a park support group that has entered into an agreement with the department or, as provided in division policy, to volunteers who significantly contribute to the division.

E. Complimentary park passes. The director or director designee (see Subsection Q of 19.5.1.7 NMAC) may issue complimentary passes as rainchecks to visitors for unused services or to resolve visitor complaints about park operation or maintenance.

F. Official use passes. The director may issue "official use only" passes to state government executive branch officials with direct oversight of the division, park advisory board members and state legislators for the performance of their official duties.

G. Advertising and promotions. To promote the parks or in exchange for advertising or promotion of parks, the director may issue free or discounted park passes or not charge fees if the director obtains the secretary's approval after the division provides the secretary with written justification showing that the issuance of park passes for promotion or advertising or not charging fees for promotional purposes provides a benefit to the division. Reduced rates for advertising must be equal to or exceed the value of the park passes [~~that~~] the division provides in exchange for receiving the reduced rates.

[19.5.2.39 NMAC - Rn, 19.5.2.38 NMAC, 6/25/2019; A, 1/1/2025]

19.5.2.42 PUBLIC ASSEMBLIES, MEETINGS:

A. Public assemblies, meetings, gatherings, demonstrations, parades and other public expressions of views are allowed within parks. A special use permit issued by the park [~~superintenent~~] superintendent is required for public assemblies, meetings, gatherings, demonstrations, parades and other public expressions of views that involve groups of:

(1) more than 10 people; or

(2) 10 people or less who are using stages, platforms or structures.

B. The superintendent shall, without unreasonable delay, issue a special use permit on proper application unless:

(1) a prior application for a special use permit for the same time and place has been made that has been or will be granted and the activities authorized by that special use permit do not reasonably allow multiple occupancy of that particular area;

(2) it reasonably appears that the event will present a danger to the public health or safety; or

(3) the event is of such nature or duration that it cannot reasonably be accommodated in the particular location applied for, considering such things as damage to park resources or facilities, interference with program activities or impairment of public use facilities.

C. If the superintendent denies a special use permit, the superintendent shall inform the applicant in writing with the reasons for the denial set forth.

D. The superintendent shall designate on a map, which shall be available in the office of the superintendent, the locations available for public assemblies. Locations may be designated as not available if such activities would:

(1) cause injury or damage to park resources;

(2) unreasonably interfere with interpretive, visitor service or other program activities, or with the division's administrative activities;

(3) substantially impair the operation of public use facilities or services of division concessionaires or contractors; or

(4) present a danger to the public health and safety.

E. The special use permit may contain such conditions as are reasonably consistent with protection and use of the park area for the purposes for which it is established. It may also contain reasonable limitations on the equipment used and the time and area within which the event is allowed.

F. It is prohibited for persons engaged in activities permitted or authorized pursuant to 19.5.2.42 NMAC to obstruct or impede pedestrians or vehicles, harass park visitors, interfere with park programs or create security or accessibility hazards.

[19.5.2.42 NMAC - Rn & A, 19.5.2.41 NMAC, 6/25/2019; A, 1/1/2025]

ENERGY, MINERALS AND NATURAL RESOURCES DEPARTMENT
STATE PARKS DIVISION

This is an amendment to 19.5.6 NMAC, amending Sections 8 through 12, 14 through 16, 18 and adding a new Section 19 effective 1/1/2025.

19.5.6.8 DAY USE PERMIT (use fees):

A. All parks (except as noted in Subsection B of 19.5.6.8 NMAC).

Per motor vehicle (residents with valid state identification card or NM license plate on the vehicle.)	$5.00
Per motor vehicle (non-resident)	[~~$5.00~~] $10.00
Walk in/bicycle	No Charge
School bus (non-resident only)	$15.00
Commercial charter bus	$50.00
RV dump station per use (resident and non-resident visitors not camping in the park)	$10.00

B. Parks with exceptions.

Rio Grande Nature Center state park	
Parking fee per motor vehicle	[~~$3.00~~] $5.00
Walk in/bicycle	No Charge
Parking fee per School bus (non-resident only)	$15.00
Commercial charter bus	$50.00
Living Desert Zoo and Gardens state park	
Adult	[~~$5.00~~] $10.00
Child (seven to 12 years old)	[~~$3.00~~] $5.00
Child (six years and under)	No Charge
Group rate adults (20 or more) per person	[~~$3.00~~] $5.00
Youth school groups (per person)	[~~$.50~~] $1.00
American zoological association reciprocal fees	
Adult	[~~$2.50~~] $5.00
Child	[~~$1.50~~] $3.00
Smokey Bear historical park	
Adult	[~~$2.00~~] $6.00
Senior (62 years or older)	$4.00
Child (seven to 12 years old)	[~~$1.00~~] $3.00
Child (six years and under)	No Charge
Youth/school groups (per person)	No Charge
Bus	$15.00

[19.5.6.8 NMAC - Rp, 19 NMAC 5.6.8, 5/1/2004; A, 1/1/2008; A, 5/15/2018; A, 1/1/2025]

19.5.6.9 CAMPING PERMIT (per night per vehicle or per walk-in/bicycle):

[~~Primitive site~~	~~$8.00~~
~~Developed site~~	~~$10.00~~
~~Developed site with electric hookup~~	~~$14.00~~
~~Developed site with electric and sewage hookups~~	~~$18.00~~
~~Electric hookup with annual camping permit~~	~~$4.00~~
~~Electric and sewage hookup with annual camping permit~~	~~$8.00~~]
Primitive site (resident with a valid state identification card or NM registration on the vehicle)	$10.00
Primitive site (non-resident)	$15.00
Developed site (resident with a valid state identification card or NM registration on the vehicle)	$15.00
Developed site (non-resident)	$20.00
Water hook-up (per day)	$5.00
Electric hook-up (per day)	$10.00
Sewer hook-up (per day)	$5.00

[19.5.6.9 NMAC - Rp, 19 NMAC 5.6.9, 5/1/2004; A, 1/1/2008; A, 1/1/2025]

19.5.6.10 ANNUAL DAY USE PASS (per vehicle):

[~~State-wide pass to all parks~~	~~$40.00~~]
Resident annual day use pass	$75.00
Non-resident annual day use pass	$150.00
Disabled veterans pass	No Charge (New Mexico resident veteran with a fifty percent or greater service-connected disability)

[19.5.6.10 NMAC - Rp, 19 NMAC 5.6.10, 5 /1/2004; A, 1/1/2008; A, 1/1/2025]

19.5.6.11 ANNUAL CAMPING PERMIT (per vehicle includes one tow vehicle upon request):

[~~New Mexico resident~~	~~$180.00~~
~~New Mexico senior resident - 62 years or older~~	~~$100.00~~
~~New Mexico physically disabled resident (see Subsection B of 19.5.2.35 NMAC)~~	~~$100.00~~
~~Out-of-state resident~~	~~$225.00~~]
New Mexico resident with valid state issued ID	$300.00
New Mexico senior resident – 62 years or older with valid state issued ID	$150.00
New Mexico physically disabled resident (see Subsection B of 19.5.2.35 NMAC)	$150.00
New Mexico active-duty military or honorably discharged veteran	$150.00
Out-of-state resident	$600.00

19.5.6.11 NMAC - Rp, 19 NMAC 5.6.11, 5/1/2004; A, 1/1/2008; A, 1/1/2013; A, 1/1/2025]

19.5.6.12 REPLACEMENT OF ANNUAL CAMPING PERMIT: [~~$10.00~~] $25.00.

[19.5.6.12 NMAC - Rp, 19 NMAC 5.6.12, 5/1/2004; A, 1/1/2008; A, 1/1/2025]

19.5.6.14 GROUP SHELTER: The following fees are for use of the facility or area only and do not include day use fees.

750 square feet or less	[~~Current: $30.00 Beginning December 1, 2018:~~] - $45.00
More than 750 square feet	[~~Current: $60.00 Beginning December 1, 2018:~~] $90.00
Rally (as designated)	
Groups less than 30 persons	[~~Current: $60.00 Beginning December 1, 2018:~~] $135.00
Groups 30 or more persons	[~~Current: $90.00 Beginning December 1, 2018:~~] $180.00

[19.5.6.14 NMAC - Rp, 19 NMAC 5.6.14, 5/1/2004; A, 1/1/2008; A, 5/15/2018; A, 5/15/2018; A, 1/1/2025]

19.5.6.15 SPECIAL USE PERMIT: [~~$15.00~~] $30.00 (see 19.5.2.40 NMAC)

[19.5.6.15 NMAC - Rp 19 NMAC 5.6.15, 5/1/2004; A, 1/1/2008; A, 1/1/2013; A, 6/25/2019; A, 1/1/2025]

19.5.6.16 CONCESSION PERMIT:

Guide, fishing services, boating and rafting excursions for Navajo Lake state park	$500.00
For other parks, guide, fishing services, boating and rafting excursions	$300.00
Educational, park resource protection services and other services	$300.00
Short term educational, park resource protection services and other services (less than five consecutive days)	$50.00

[19.5.6.16 NMAC - Rp, 19 NMAC 5.6.16, 5/1/2004; A, 6/30/2004; A, 1/1/2008; A, 1/1/2025]

19.5.6.18 MEETING, EVENT AND LODGING FACILITIES (per day): The following fees are for use of the facility or area only and do not include applicable day use or camping fees.

A. Meeting room, conference room, classroom.

Park open hours	[~~Current: $30.00 Beginning December 1, 2018:~~] Large for entire day $200.00 Small for entire day $100.00 Large for partial day (four hours) $50.00 Small for partial day (four hours) $25.00
Damage and cleaning deposit (reimbursed upon satisfactory inspection)	$50.00

. Special event facility.

Park open hours Per day cost will vary according to certain seasons. Please refer to the division website.	[~~Current: $125.00 Beginning December 1, 2018:~~] Season $1,000.00 Off-season $500.00
Damage and cleaning deposit (reimbursed upon satisfactory inspection)	$250.00
Park after hours Per day cost will vary according to certain seasons. Please refer to the division website.	[~~Current: $275.00 Beginning December 1, 2018:~~] Season $1,500.00 Off-season $700.00
Damage and cleaning deposit (reimbursed upon satisfactory inspection)	$350.00

C. Yurts (per night).

Rental inclusive of camping fee for two vehicles. Additional vehicles will be subject to day use or camping fees as applicable. Per night fee may be less on certain days or in certain seasons. Please refer to the division website.	[~~Beginning July 1, 2018:~~] Season $150.00 Off-season $80.00
Damage and cleaning deposit (reimbursed upon satisfactory inspection)	$100.00

D. Cabins (per night).

Rental inclusive of camping fees for two vehicles. Additional vehicles will be subject to day use or camping fees as applicable. Per night fee may be less on certain days or in certain seasons. Please refer to the division website.	Season $150.00 Off-season $80.00
Damage and cleaning deposit (reimbursed upon satisfactory inspection)	$100.00

E. Corrals (per night).

Small	$30.00
Large	$50.00

F. [~~**Wildlife blinds (per night).**~~

~~Season~~	~~$75.00~~
~~Off-season~~	~~$25.00~~

~~**G.**~~] Persons using the facilities listed in 19.5.6.18 NMAC may be required to enter into an agreement with the division that contains conditions of use.

[19.5.6.18 NMAC - Rp, 19 NMAC 5.6.18, 5/1/2004; A, 1/1/2008; A, 1/1/2013; A, 5/15/2018; A, 1/1/2025]

19.5.6.19 FEE CHANGES: The division shall review the fees in 19.5.6 NMAC every five years and the director may change any or all the fees to reflect the *Chained Consumer Price Index for Urban Consumers*. Any fee change shall be rounded to the nearest dollar.

[19.5.6.19 NMAC - N, 1/1/2025]

HEALTH CARE AUTHORITY
MEDICAL ASSISTANCE DIVISION

The New Mexico Health Care Authority approved the repeal of 8.321.2 NMAC - Specialized Behavioral Health Services, Specialized Behavioral Health Provider Enrollment and Reimbursement (filed 7/22/2021) and replaced it with 8.321.2 NMAC - Specialized Behavioral Health Services, Specialized Behavioral Health Provider Enrollment and Reimbursement (adopted on 11/5/2024), effective 12/10/2024.

HEALTH CARE AUTHORITY
MEDICAL ASSISTANCE DIVISION

TITLE 8 SOCIAL SERVICES

CHAPTER 321 SPECIALIZED BEHAVIORAL HEALTH SERVICES

PART 2 SPECIALIZED BEHAVIORAL HEALTH PROVIDER ENROLLMENT AND REIMBURSEMENT

8.321.2.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).

[8.321.2.1 NMAC - Rp, 8.321.2.1 NMAC, 12/10/2024]

8.321.2.2 SCOPE: The rule applies to the general public.
[8.321.2.2 NMAC - Rp, 8.321.2.2 NMAC, 12/10/2024]

8.321.2.3 STATUTORY AUTHORITY: The New Mexico Medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq., NMSA 1978.
[8.321.2.3 NMAC - Rp, 8.321.2.3 NMAC, 12/10/2024]

8.321.2.4 DURATION: Permanent.
[8.321.2.4 NMAC - Rp, 8.321.2.4 NMAC, 12/10/2024]

8.321.2.5 EFFECTIVE DATE: December 10, 2024, unless a later date is cited at the end of a section.
[8.321.2.5 NMAC - Rp, 8.321.2.5 NMAC, 12/10/2024]

8.321.2.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.321.2.6 NMAC - Rp, 8.321.2.6 NMAC, 12/10/2024]

8.321.2.7 DEFINITIONS: [**RESERVED**]

8.321.2.8 MISSION STATEMENT: We ensure New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.321.2.8 NMAC - Rp, 8.321.2.8 NMAC, 12/10/2024]

8.321.2.9 GENERAL PROVIDER INSTRUCTION:

A. Health care to New Mexico (NM) eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by the HCA medical assistance division (MAD). Upon approval of a NM MAD provider participation agreement (PPA) a licensed practitioner, a facility or other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing MAD covered services to an eligible recipient. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. Information necessary to participate in health care programs administered by HCA or its authorized agents, including NM administrative code (NMAC) program rules, program policy manuals, billing instructions, supplements, utilization review (UR) instructions, and other pertinent materials is available on the HCA website, on other program specific websites or in hard copy format. When approved, a provider receives instructions on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, providers and practitioners must adhere to the provisions of their MAD PPA and all applicable statutes, regulations, rules, and executive orders. MAD or its selected claims processing contractor issues payment to a provider using the electronic funds transfer (EFT) only. Providers must supply necessary information as outlined in the PPA for payment to be made.

B. Services must be provided within the licensure for each facility and scope of practice for each provider and supervising or rendering practitioner. Services must be in compliance with the statutes, rules and regulations of the applicable practice act. Providers must be eligible for reimbursement as described in 8.310.2 NMAC and 8.310.3 NMAC.

C. The following independent providers with active licenses are eligible to be reimbursed directly for providing MAD covered behavioral health professional services unless otherwise restricted or limited by NMAC rules:

(1) a physician licensed by the board of medical examiners or board of osteopathy who is board eligible, or board certified in psychiatry, to include the groups they form;

(2) a psychologist (Ph.D., Psy.D. or Ed.D.) licensed as a clinical psychologist by the NM regulation and licensing department's (RLD) board of psychologist examiners, to include the groups they form;

(3) a licensed independent social worker (LISW) or a licensed clinical social worker (LCSW) licensed by RLD's board of social work examiners, to include the groups they form;

(4) a licensed professional clinical counselor (LPCC) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(5) a licensed marriage and family therapist (LMFT) licensed by RLD's counseling and therapy practice board, to include the groups they form;

(6) a licensed alcohol and drug abuse counselor (LADAC) licensed by RLD's counseling and therapy practice board or a certified alcohol and drug abuse counselor (CADC) certified by the NM credentialing board for behavioral health professionals (CBBHP). Independent practice is for alcohol and substance use diagnoses only. The LADAC or CADC may provide therapeutic services that may include treatment of clients with co-occurring disorders or dual diagnoses in an integrated behavioral health setting in which an interdisciplinary team has developed an interdisciplinary treatment plan that is co-authorized by an independently licensed counselor or therapist. The treatment of a mental health disorder must be supervised by an independently licensed counselor or therapist; or

(7) a clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) licensed by the NM board of nursing and certified in psychiatric nursing by a national nursing organization, to include the groups they form, who can furnish services to adults or children as their certification permits; or

(8) a licensed professional art therapist (LPAT) licensed by RLD's counseling and therapy practice board, and certified for independent practice by the art therapy credentials board (ATCB);

(9) an occupational therapist licensed by the RLD board of examiners for occupational therapy; who is facilitating occupational performance and managing an individual's mental health functioning and performance in accordance with the NM occupational therapy act; or

(10) an out-of-state provider rendering a service from out-of-state must meet their state's licensing and certification requirements which are acceptable when deemed by MAD to be substantially equivalent to the license.

D. The following agencies are eligible to be reimbursed for providing behavioral health professional services when all conditions for providing services are met:

(1) a community mental health center (CMHC);

(2) a federally qualified health center (FQHC);

(3) an Indian health service (IHS) hospital, clinic or FQHC;

(4) a PL 93-638 tribally operated hospital, clinic or FQHC;

(5) to the extent not covered by Paragraphs (3) and (4) of Subsection D of 8.321.2.9 NMAC above, an "Indian health care provider (IHCP)" defined in 42 code of federal regulations §438.14(a).

(6) a children, youth and families department (CYFD) facility;

(7) a hospital and its outpatient facility;

(8) a core service agency (CSA);

(9) a CareLink NM health home (CLNM HH);

(10) a crisis triage center licensed by the department of health (DOH);

(11) a behavioral health agency (BHA);

(12) an opioid treatment program in a methadone clinic;

(13) a political subdivision of the state of NM;

(14) a crisis services community provider as a BHA; and

(15) a school based health center.

E. A behavioral health service rendered by a licensed practitioner listed in Paragraph (2) of Subsection E of 8.321.2.9 NMAC whose scope of licensure does not allow them to practice independently or a non-licensed practitioner listed in Paragraph (3) of Subsection E of 8.321.2.9 NMAC is covered to the same extent as if rendered by a practitioner licensed for independent practice, when the supervisory requirements are met consistent with the practitioner's licensing board within their scope of practice and the service is provided through and billed by one of the provider agencies listed in numbers Paragraphs (1) through (15) of Subsection D of 8.321.2.9 NMAC. All services must be delivered according to the medicaid regulation and current version of the BH policy and billing manual. If the service is an evaluation, assessment, or therapy service rendere d by the practitioner and supervised by an independently licensed practitioner, the independently licensed practitioner's practice board must specifically allow them to supervise the non-independent practitioner.

(1) Specialized behavioral health services, other than evaluation, assessment, or therapy services, may have specific rendering practitioner requirements which are detailed in each behavioral health services section of 8.321.2.9 NMAC.

(2) The non-independently licensed rendering practitioner with an active license must be one of the following:

(a) a licensed master of social work (LMSW) licensed by RLD's board of social work examiners;

(b) a licensed mental health counselor (LMHC) licensed by RLD's counseling and therapy practice board;

(c) a licensed professional mental health counselor (LPC) licensed by RLD's examiner board;

(d) a licensed associate marriage and family therapist (LAMFT) licensed by RLD's examiner board;

(e) a psychologist associate licensed by the RLD's psychologist examiners board;

(f) a licensed substance abuse associate (LSAA) licensed by RLD's counseling and therapy practice board will be eligible for reimbursement aligned with each tier level of designated scope of practice determined by the board;

(g) a registered nurse (RN) licensed by the NM board of nursing under the supervision of a certified nurse practitioner, clinical nurse specialist or physician; or

(h) a licensed physician assistant certified by the state of NM if supervised by a behavioral health physician or DO licensed by RLD's examiner board.

(3) Non-licensed practitioners working under RLD board approved supervisor, must be one of the following:

(a) a master's level behavioral health intern;

(b) a psychology intern including psychology practicum students, pre-doctoral internship;

(c) a pre-licensure psychology post doctorate student;

(d) a certified peer support worker;

(e) a certified family peer support worker;

(f) a certified youth peer support specialist;

(g) a community support worker (CSW);

(h) a community health worker (CHW);

(i) a tribal community health representative (TCHR); or

(j) a provisional or temporarily licensed master's level behavioral health professional.

(4) The rendering practitioner must be enrolled as a MAD provider.

F. An eligible recipient under 21 years of age may be identified through a tot to teen health check, self-referral, referral from an agency (such as a public school, childcare provider, or other practitioner) when they are experiencing behavioral health concerns.

G. Either as a separate service or a component of a treatment plan or a bundled service, the following services are not MAD covered benefits:

(1) hypnotherapy;

(2) biofeedback;

(3) conditions that do not meet the standard of medical necessity as defined in 8.302.1 NMAC;

(4) educational or vocational services related to traditional academic subjects or vocational training;

(5) experimental or investigational procedures, technologies or non-drug therapies and related services;

(6) activity therapy, group activities and other services which are primarily recreational or diversional in nature;

(7) electroconvulsive therapy;

(8) services provided by a behavioral health practitioner who is not in compliance with the statutes, regulations, rules or renders services outside their scope of practice;

(9) treatment of intellectual disabilities alone;

(10) services not considered medically necessary for the condition of the eligible recipient;

(11) services for which prior authorization is required but was not obtained; and

(12) milieu therapy.

H. All behavioral health services must meet the definition of medical necessity found in 8.302.1 NMAC. Performance of a MAD covered behavioral health service cannot be delegated to a provider or practitioner not licensed for independent practice except as specified within this rule, within their practice board's scope and practice and in accordance with applicable federal, state, and local statutes, laws, and rules. When a service is performed by a supervised practitioner, the supervision of the service cannot be billed separately or additionally. Other than agencies as allowed in Subsections D and E of 8.321.2.9 NMAC, a behavioral health provider cannot, themselves, as a rendering provider, bill for a service for which they were providing supervision, and the service was in part or wholly performed by a different individual. Behavioral health services are reimbursed as follows, except when otherwise described within a particular specialized service's reimbursement section.

(1) Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing information. Reimbursement is made to a provider for covered services at the lesser of the following:

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

(b) the provider's billed charge. The provider's billed charge must be its usual and customary charge for services ("usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service).

(2) Reimbursement is made for an Indian health service (IHS) agency, a PL 93-638 tribal health facility, a federally qualified health center (FQHC), any other "Indian health care provider (IHCP)" as defined in 42 Code of Federal Regulations §438.14(a), rural health clinic, or hospital-based rural health clinic by following its federal guidelines and special provisions as detailed in 8.310.4 and 8.310.12 NMAC.

I. All behavioral health services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after service is furnished but before a payment is made, or after the payment is made; see 8.310.2 NMAC. The provider must contact HCA or its authorized agents to request UR instructions. It is the provider's and practitioner's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for authorization of services. A specialized behavioral health service may have additional prior authorization requirements listed in that service's prior authorization subsection. All prior authorization procedures must follow federal parity law.

J. For an eligible recipient to access behavioral health services, a practitioner must complete a diagnostic evaluation, progress and treatment notes and teaming notes, if indicated. Exceptions to this whereby a treatment or set of treatments may

be performed before a diagnostic evaluation has been done, utilizing a provisional diagnosis based on screening results are outlined in 8.321.2.15, 8.321.2.19 and 8.321.2.35 NMAC and in the BH policy and billing manual. For a limited set of treatments, (i.e. four or less), no treatment plan is required. All documentation must be signed, dated and placed in the eligible recipient's file. All documentation must be made available for review by HCA or its designees in the eligible recipient's file (see the BH policy and billing manual for specific instructions).

K. For recipients meeting the NM state definition of serious mental illness (SMI) for adults or severe emotional disturbances (SED) for recipients under 18 years of age or a substance use disorder (SUD) for any age, a comprehensive assessment or diagnostic evaluation and treatment plan must be completed (see the BH policy and billing manual for specific instructions).

(1) A comprehensive assessment and treatment plan can only be billed by the agencies listed in Subsection D of 8.321.2.9 NMAC.

(2) Behavioral health treatment plans can be developed by individuals employed by the agency who have Health Insurance Portability and Accountability Act (HIPAA) training, are working within their scope of practice, and are working under the supervision of the rendering provider who must be a RLD board approved supervisor.

(3) A comprehensive assessment and treatment plan cannot be billed if care coordination is being billed through bundled service packages such as case rates, value-based purchasing agreements, high fidelity wraparound or CareLink NM (CLNM) health homes.

L. MAD covers treatment plans, and updates, created with interdisciplinary teams for out-patient recipients meeting the NM state definition for SMI, SED, or SUD in which multiple provider disciplines are engaged to address co-occurring conditions, or other social determinants of health.

(1) Coverage, purpose and frequency of interdisciplinary team meetings:

(a) provides the central learning, decision-making, and service integrating elements that weave practice functions together into a coherent effort for helping a recipient meet needs and achieve life goals; and

(b) covered team meetings resulting in treatment plan changes or updates are limited to an annual review, when recipient conditions change, or at critical decision points in the recipient's progress to recovery.

(2) The team consists of:

(a) a lead agency, which must be one of the agencies listed in Subsection D of 8.321.2.9 NMAC. This agency has a designated and qualified team lead who prepares team members, convenes and organizes meetings, facilitates the team decision-making process, and follows up on commitments made;

(b) a participating provider that is a MAD enrolled provider that is either already treating the recipient or is new to the case and has the expertise pertinent to the needs of the individual. This provider may practice within the same agency but in a differing discipline, or outside of the lead agency;

(c) other participating providers not enrolled with MAD, other subject matter experts, and relevant family and natural supports may be part of the team, but are not reimbursed through MAD; and

(d) the recipient, who is the subject of this treatment plan update, must be a participating member of every teaming meeting.

(3) Reimbursement:

(a) only the team lead and two other MAD enrolled participating providers or agencies may bill for the interdisciplinary team update. When more than three MAD enrolled providers are engaged within the session, the team decides who will bill based on the level of effort or change within their own discipline.

(b) when the team lead and only one other provider meet to update the treatment plan, the definition of teaming is not met and the treatment plan update may not be billed using the interdisciplinary teaming codes.

(c) the six elements of teaming may be performed by using a variety of media (with the person's knowledge and consent) e.g., texting members to update them on an emergent event; using email communications to ask or answer questions; sharing assessments, plans and reports; conducting conference calls via telephone; using telehealth platforms conferences; and, conducting face-to-face meetings with the person present when key decisions are made. Only conducting the final face-to-face meeting with the recipient present when key decisions are made that result in the updates to the treatment plan, is a billable event.

(d) when updates to the treatment plan, that was developed within the comprehensive assessment, are developed using the interdisciplinary teaming model described in the BH policy and billing manual, service codes specific for interdisciplinary teaming may be billed. If the teaming model is not used, only the standard codes for updating the treatment plan can be billed. An update to the treatment plan using a teaming method approach and an update to the treatment plan not using the teaming method approach, cannot both be billed.

(e) billing instructions are found in the BH policy and billing manual.

M. For recipients with behavioral health diagnoses and other co-occurring conditions, or other social determinants of health meeting medical necessity,

and for whom multiple provider disciplines are engaged, MAD covers treatment plan development and one subsequent update per year for an interdisciplinary team.

(1) The team consists of:

(a) a lead MAD enrolled provider that has primary responsibility for coordinating the interdisciplinary team, convenes and organizes meetings, facilitates the team decision-making process, and follows up on commitments made;

(b) a participating MAD enrolled provider from a different discipline;

(c) other participating providers not enrolled with MAD, other subject matter experts, and relevant family and natural supports may be part of the team, but are not reimbursed through MAD; and

(d) the recipient, who is the subject of this treatment plan development and update, must be a participating member of each team meeting.

(2) Reimbursement:

(a) only the team lead and one other MAD enrolled participating provider may bill for a single session. When more than two MAD enrolled providers are engaged with the session, the team decides who will bill based on the level of effort or change within their own discipline;

(b) this treatment plan development and subsequent update to the original plan can only be billed twice within one year; and

(c) billing instructions are found in the BH policy and billing manual.

N. All specialized behavioral health services should be delivered in the least restrictive setting. Least restrictive settings will differ between services and facilities and are generally defined as a physical setting which places the least restraint on the client's freedom of movement and opportunity for independence and enables an individual to function with as much choice and self-direction as safely appropriate. In addition, access to or receipt of one service may not be contingent on requiring an individual to obtain or utilize any other service; for example, a housing service may not require a treatment component, nor may an outpatient treatment service require participation in housing. Multiple services may be encouraged, under appropriate circumstances, but may not be required.

O. Site visits must be conducted for specialized behavioral health services. Site visit requirements are outlined in the BH policy and billing manual.

[8.321.2.9 NMAC - Rp, 8.321.2.9 NMAC, 12/10/2024]

8.321.2.10 ADULT ACCREDITED RESIDENTIAL TREATMENT CENTER (AARTC) FOR ADULTS WITH SUBSTANCE USE DISORDERS: To help an eligible recipient 18 years of age and older, who has been diagnosed as having a SUD, and the need for AARTC has been identified in the eligible recipient's diagnostic evaluation as meeting criteria of the American society of addiction medicine (ASAM) level of care three for whom a less restrictive setting is not appropriate, MAD pays for services furnished to them by an AARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA).

A. Eligible facilities:

(1) To be eligible to be reimbursed for providing AARTC services to an eligible recipient, an AARTC facility:

(a) must be accredited by JC, COA, or CARF as an adult (18 and older) residential treatment facility;

(b) must be certified through an application process with the behavioral health services division (BHSD) which includes site visits. Site visit requirements are outlined in the BH policy and billing manual;

(c) must have written policies and procedures specifying ASAM level of care three criteria as the basis for accepting eligible recipients into the sub-level treatment program;

(d) must meet ASAM treatment service requirements for the ASAM level of care three recipients it admits into each sub-level of care;

(e) must provide medication assisted treatment (MAT) for opioid use disorder (OUD), as indicated. See 8.321.2.28 NMAC for MAT requirements. An AARTC may coordinate with another agency for provision of MAT services when they are not provided by the AARTC; an AARTC may not exclude recipients from receiving AARTC services on the basis of receiving MAT services;

(f) all licensed practitioners shall be trained in ASAM principles and levels of care. The ASAM training must comprehensively cover the expected treatment expectations of the ASAM level 3 sub-level treatment programs;

(g) prior to the initial hire and every three years thereafter employees must pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16-12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs;

(h) must maintain appropriate drug permit required, issued by the state board of pharmacy, as applicable;

(i) must maintain appropriate food service permit required, issued by the New Mexico environmental department (NMED), as applicable; and

(j) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) An out-of-state or MAD enrolled border AARTC must have JC, CARF or COA accreditation, use ASAM level three criteria for accepting recipients, and be licensed in its own state as an AARTC residential treatment facility.

B. Coverage criteria:

(1) Treatment must be provided under the direction of an independently licensed clinician or practitioner as defined by ASAM criteria level three for the sub-level of treatment being rendered.

(2) Treatment shall be based on the eligible recipient's individualized treatment plan rendered by the AARTC facility's practitioners, within the scope and practice of their professions as defined by state law, rule or regulation. See Subsection B of 8.321.2.9 NMAC for general behavioral health professional requirements.

(3) The following services shall be performed by the AARTC agency to receive reimbursement from MAD:

(a) diagnostic evaluation, necessary psychological testing, and development of the eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provision of regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan, and according to ASAM guidelines for level three, residential care, and the specific sub-level of care for which that client meets admission criteria;

(c) facilitation of age-appropriate life skills development;

(d) assistance to the eligible recipient in their self-administration of medication in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals as necessary, and provide follow-up to the eligible recipient; and

(f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable.

(4) Admission and treatment criteria based on the sub-levels of ASAM level three criteria must be met. Length of stay is determined by medical necessity. The differing sub-levels of ASAM level three are based on the intensity of clinical services, particularly as demonstrated by the degree of involvement of medical and nursing professionals. The defining characteristic of level three ASAM criteria is that they serve recipients who need safe and stable living environments to develop their recovery skills. They are transferred to lower levels of care when they have established sufficient skills to safely continue treatment without the immediate risk of relapse, continued use, or other continued problems, and are no longer in imminent danger of harm to themselves or others.

(5) Levels of care without withdrawal management:

(a) clinically managed low-intensity residential services as specified in ASAM level of care 3.1 are covered for recipients whose condition meets the criteria for ASAM 3.1:

(i) is often a step down from a higher level of care and prepares the recipient for transition to the community and outpatient services; and

(ii) requires a minimum of five hours per week of recovery skills development.

(b) clinically managed population-specific high-intensity residential services as specified in ASAM levels of care 3.3 and 3.5 are covered for recipients whose condition meets the criteria of ASAM level 3.3 or 3.5.

(i) level 3.3 meets the needs of recipients with cognitive difficulties needing more specialized individualized services. Cognitive impairments can be due to aging, traumatic brain injury, acute but lasting injury, or illness.

(ii) level 3.5 offers a higher intensity of service not requiring medical monitoring.

(c) medically monitored intensive inpatient services as specified in ASAM level of care 3.7 are covered for recipients whose condition meets the criteria for ASAM level 3.7:

(i) 3.7 level is an organized service delivered by medical and nursing professionals which provides 24-hour evaluation and monitoring services under the direction of a physician or clinical nurse practitioner who is available by phone 24-hours a day;

(ii) nursing staff is on-site 24-hours a day;

(iii) other interdisciplinary staff of trained clinicians may include counselors, social workers, emergency medical technicians with documentation of three hours of annual training in SUD, and psychologists available to assess and treat the recipient and to obtain and interpret information regarding recipient needs.

(6) Withdrawal management (WM) levels of care:

(a) clinically managed residential withdrawal management services as specified in ASAM level of care 3.2WM for recipients whose condition meets the criteria for ASAM 3.2WM:

(i) managed by behavioral health professionals, with protocols in

place should a patient's condition deteriorate and appear to need medical or nursing interventions;

(ii) ability to arrange for appropriate laboratory and toxicology tests;

(iii) a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the recipient's understanding of SUD, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment;

(iv) the recipient remains in a level 3.2WM program until withdrawal signs and symptoms are sufficiently resolved that the recipient can be safely managed at a less intensive level of care; or the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated; and

(v) 3.2WM's length of stay is typically 3 - 5 days, after which transfer to another level of care is indicated.

(b) medically monitored residential withdrawal management services as specified in ASAM level of care 3.7WM for recipients whose condition meets the criteria for ASAM 3.7WM:

(i) services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers, emergency medical technicians with documentation of three hours of annual training in SUD, or other health and technical personnel under the direction of a licensed physician;

(ii) monitored by medical or nursing professionals, with 24-hour nursing care and physician visits as needed, with protocols in place should a patient's condition deteriorate and appear to need intensive inpatient withdrawal management interventions;

(iii) ability to arrange for appropriate laboratory and toxicology tests;

(iv) a range of cognitive, behavioral, medical, mental health and other therapies administered on an individual or group basis to enhance the recipient's understanding of SUD, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment; and

(v) the recipient remains in a level 3.7WM program until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care; or the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated;

(vi) 3.7WM typically last for no more than seven days.

C. Covered services: AARTCs treating all recipients meeting ASAM level three criteria. MAD covers residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A clinically managed facility must provide 24-hour care with trained staff.

D. Non-covered services: AARTC services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with AARTC services to an eligible recipient:

(1) comprehensive community support services (CCSS), except when provided by a CCSS agency in discharge planning for the eligible recipient from the facility;

(2) services for which prior approval was not requested and approved;

(3) services furnished to ineligible individuals;

(4) formal educational and vocational services which relate to traditional academic subjects or vocational training; and

(5) activity therapy, group activities, and other services primarily recreational or diversional in nature.

E. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the eligible recipient and in accordance with ASAM and accreditation standards. The interdisciplinary team must review the treatment plan at least every 15 days.

F. Prior authorization: Prior authorization is not required for up to five days for eligible recipients meeting ASAM level three criteria to facilitate immediate admission and treatment to the appropriate level of care. Within that five day period, the provider must furnish notification of the admission and if the provider believes that continued care beyond the initial five days is medically necessary, prior authorization must be obtained from MAD or its designee. For out-of-state AARTCs prior authorization is required prior to admission. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Follow up auditing is done by the accrediting agency per their standards.

G. Reimbursement: An AARTC agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

(1) MAD reimbursement covers services considered routine in the residential setting. Routine services include, but

are not limited to, counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(2) Services which are not covered in routine services include other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services. These services are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

(3) MAD does not cover room and board.

(4) Detailed billing instructions can be accessed in the BH policy and billing manual. [8.321.2.10 NMAC - Rp, 8.321.2.10 NMAC, 12/10/2024]

8.321.2.11 ADULT ACCREDITED RESIDENTIAL TREATMENT CENTER (AARTC) FOR ADULTS WITH SERIOUS MENTAL HEALTH CONDITIONS: To help an eligible recipient 18 years of age and older, who has been diagnosed as having a serious mental health condition, and the need for AARTC has been identified in the eligible recipient's diagnostic evaluation as meeting criteria of the level of care utilization system (LOCUS) for psychiatric and SUD services level of care five for whom a less restrictive setting is not appropriate. MAD pays for services furnished to them by an AARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA).

A. Eligible facilities:

(1) To be eligible to receive reimbursement for providing AARTC services to an eligible recipient, an AARTC facility:

(a) must be accredited by JC, COA, or CARF as an adult (18 and older) residential treatment facility;

(b) must be certified through an application process with BHSD which includes site visits. Site visit requirements are outlined in the BH policy and billing manual;

(c) must have written policies and procedures specifying utilization of the LOCUS evaluation parameters for assessment of service needs and ensuring that based on the dimensional rating scale, clients meet LOCUS level 5 criteria as the basis for accepting eligible recipients into the treatment program;

(d) must meet LOCUS level five service definitions for the care environment, clinical services, support services, and crisis stabilization and prevention services;

(e) must assess for and treat co-occurring SUDs;

(f) must provide or refer eligible recipients for MAT for SUD, if appropriate; to include access to buprenorphine and methadone, if appropriate and desired by the recipient. Programs may not exclude recipients from receiving AARTC services on the basis of receiving or desiring to receive MAT services.

(g) must train all clinicians or practitioners in the LOCUS for psychiatric and SUD services. The LOCUS training must be conducted by a LOCUS approved trainer and must be comprehensive in covering the evaluation parameters for assessment of service needs and level of care definitions for LOCUS level 5 services;

(h) prior to the initial hire and every three years thereafter employees must pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16-12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs;

(i) must maintain appropriate drug permit required, issued by the state board of pharmacy, as applicable;

(j) must maintain appropriate food service permit required, issued by the NMED, as applicable; and

(k) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) An out-of-state or MAD enrolled border AARTC must have JC, CARF or COA accreditation, use LOCUS level five criteria for accepting recipients, and be licensed in its own state as an AARTC residential treatment facility.

B. Coverage criteria:

(1) Treatment must be provided under the direction of an independently licensed clinician/practitioner and the program must have sufficient staffing to meet the LOCUS level five clinical capabilities description.

(2) Treatment shall be based on the eligible recipient's individualized treatment plan rendered by the AARTC facility's practitioners, within the scope and practice of their professions as defined by state law, rule or regulation. See Subsection B of 8.321.2.9 NMAC for general behavioral health professional requirements.

(3) The following services shall be performed by the AARTC agency to receive reimbursement from MAD:

(a) diagnostic evaluation, necessary psychological testing, and development of the eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provision of regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan, and according to LOCUS level five service descriptions the care environment, clinical services, support services, and crisis stabilization and prevention services;

(c) facilitation of age-appropriate life skills development;

(d) assistance to the eligible recipient in their self-administration of medication in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals as necessary, and provide follow-up to the eligible recipient; and

(f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable.

(4) Admission and treatment criteria based on the LOCUS level five criteria based on the dimensional evaluation of service needs. Length of stay duration is determined by medical necessity and ongoing LOCUS level five criteria and symptomology. The LOCUS levels of care are based on the intensity of clinical services, particularly as demonstrated by the degree of involvement of psychiatric, medical, and nursing professionals. The defining characteristic of LOCUS level five is that it serves recipients who need a medically monitored residential setting for stabilization and treatment. Recipients are transferred to lower levels of care when they have established sufficient skills to safely continue treatment at a lower level of care.

(5) Sub-levels of level five level of care:

(a) moderate intensity long term residential treatment services as specified in LOCUS level of care 5c are covered for recipients whose condition meets the criteria for LOCUS Level 5c and who are experiencing long term and persistent disabilities that require extended rehabilitation and skill building to develop capacity for community living:

(b) moderate intensity intermediate stay residential treatment programs as specified in LOCUS levels of care 5b are covered for recipients whose condition meets the criteria of LOCUS level 5c and who need rehabilitation and skill building following stabilization of a crisis or to prevent precipitous deterioration in functioning.

(c) intensive short term residential services as specified in LOCUS level of care 5a are covered for recipients whose condition meets the criteria for LOCUS level 5a and who are stepping down from acute inpatient care or people who are in crisis but who do not require the security of a locked facility.

C. Covered services: AARTCs treating all recipients meeting LOCUS level five criteria. MAD covers residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A LOCUS level five AARTC facility must provide 24-hour care with trained staff.

D. Non-covered services: AARTC services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with AARTC services to an eligible recipient:

(1) Comprehensive community support services (CCSS), except when provided by a CCSS agency in discharge planning for the eligible recipient from the facility;

(2) Services for which prior approval was not requested and approved;

(3) Services furnished to ineligible individuals;

(4) Formal educational and vocational services which relate to traditional academic subjects or vocational training; and

(5) Activity therapy, group activities, and other services primarily recreational or diversional in nature.

E. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the eligible recipient and in accordance with LOCUS and accreditation standards. The interdisciplinary team must review the treatment plan at least every 15 days.

F. Prior authorization: Prior authorization is not required for up to five days for eligible recipients meeting LOCUS level 5 criteria to facilitate immediate admission and treatment to the appropriate level of care. Within that five day period, the provider must furnish notification of the admission and if the provider believes that continued care beyond the initial five days is medically necessary, prior authorization must be obtained from MAD or its designee. For out-of-state AARTCs prior authorization is required prior to admission. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Follow-up auditing is done by the accrediting agency per their standards.

G. Reimbursement: An AARTC agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

(1) MAD reimbursement covers services

considered routine in the residential setting. Routine services include, but are not limited to, counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(2) Services which are not covered in routine services include other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services. These services are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

(3) MAD does not cover room and board.

(4) Detailed billing instructions can be accessed in the BH policy and billing manual.

[8.321.2.11 NMAC - N, 8.321.2.11 NMAC, 12/10/2024]

8.321.2.12 ACCREDITED RESIDENTIAL TREATMENT CENTER FOR YOUTH (ARTC): To help an eligible recipient under 21 years of age when the need for ARTC has been identified in the eligible recipient's tot to teen health check screen (EPSDT) program (42 CFR section 441.57) or other diagnostic evaluation, and for whom a less restrictive setting is not appropriate, MAD pays for services furnished to them by an ARTC accredited by the joint commission (JC), the commission on accreditation of rehabilitation facilities (CARF) or the council on accreditation (COA). A determination must be made that the eligible recipient needs the level of care (LOC) for services furnished in an ARTC. This determination must have considered all environments which are least restrictive, including but not limited to outpatient therapy, intensive outpatient, day treatment services, group home services.

A. Eligible facilities:

(1) In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing ARTC services to an eligible recipient, an ARTC facility:

(a) must provide a copy of its JC, COA, or CARF accreditation as a children's residential treatment facility;

(b) must provide a copy of its CYFD ARTC facility license per 7.20.12 NMAC and certification per 7.20.11 NMAC;

(c) must have written utilization review (UR) plans in effect which provide for review of the eligible recipient's need for the ARTC that meet federal requirements; see 42 CFR Section 456.201 through 456.245; and

(d) must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

(2) If the ARTC is operated by IHS or by a federally recognized tribal government, the youth based facility must meet CYFD ARTC licensing and certification requirements, but is not required to be licensed or certified by CYFD. In lieu of receiving a license and certification, CYFD will provide MAD copies of its facility findings and recommendations. MAD will work with the facility to address recommendations. Details related to findings and recommendations for an IHS or federally recognized tribal government's ARTC are detailed in the BH policy and billing manual; and

(3) In lieu of NM CYFD licensure, an out-of-state or MAD enrolled border ARTC facility must have JC, COA or CARF accreditation and be licensed in its own state as an ARTC residential treatment facility.

B. Covered services: MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. An ARTC facility must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the eligible recipient. The ARTC will coordinate with the educational program of the recipient, if applicable.

(1) Treatment must be furnished under the direction of a MAD enrolled board eligible or certified psychiatrist.

(2) Treatment must be based on the eligible recipient's individualized treatment plans rendered by the ARTC facility's practitioners, within the scope and practice of their professions as defined by state law, rule or regulation. See Subsection B of 8.321.2.9 NMAC for general behavioral health professional requirements.

(3) Treatment must be reasonably expected to improve the eligible recipient's condition. The treatment must be designed to reduce or control symptoms or maintain levels of functioning. Avoiding acute psychiatric hospitalization or further deterioration are also reasonable expectations of treatment.

(4) The following services must be performed by the ARTC agency to receive reimbursement from MAD:

(a) performance of necessary evaluations, psychological testing and development of the eligible recipient's treatment plan, while ensuring that evaluations already performed are not repeated;

(b) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan;

(c) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the eligible recipient;

(d) assistance to the eligible recipient in their self-administration of medication

in compliance with state statute, regulation and rules;

(e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals, as necessary, and provide follow-up to the eligible recipient;

(f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable;

(g) non-medical transportation services needed to accomplish the eligible recipient's treatment objective; and

(h) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the eligible recipients.

C. Non-covered services: ARTC services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with ARTC services to an eligible recipient:

(1) CCSS, except when provided by a CCSS agency in discharge planning for the eligible recipient from the facility;

(2) services for which prior approval was not requested and approved;

(3) services furnished to ineligible individuals; ARTC and group services are covered only for eligible recipients under 21 years of age;

(4) formal educational and vocational services which relate to traditional academic subjects or vocation training; and

(5) activity therapy, group activities, and other services primarily recreational or diversional in nature.

D. Treatment plan: The treatment plan must be developed by a team of professionals in consultation with the eligible recipient, their parent, legal guardian and others in whose care they will be released after discharge. The plan must be developed within 14 calendar days of the eligible recipient's admission to an ARTC facility. The interdisciplinary team must review the treatment plan at least every 30 calendar days. In addition to the requirements of Subsection K of 8.321.2.9 NMAC, all supporting documentation must be available for review in the eligible recipient's file. The treatment plan must also include a statement of the eligible recipient's cultural needs and provision for access to cultural practices.

E. Prior authorization: Before any ARTC services are furnished to an eligible recipient, prior authorization is required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. Reimbursement: An ARTC agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information.

(1) The MAD fee schedule is based on actual cost data submitted by the ARTC agency. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration and consultation.

(a) The MAD reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to: counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not covered in routine services include other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory or radiology services, are billed directly by the applicable providers and are governed by applicable sections of NMAC rules.

(c) Services which are not covered in the routine rate and are not a MAD covered service include services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each eligible recipient is built in for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, an ARTC agency cannot bill nor be reimbursed for days when the eligible recipient is absent from the facility.

(3) An ARTC agency must submit annual cost reports in a form prescribed by MAD. Cost reports are due 90 calendar days after the close of the agency's fiscal year end.

(a) If an agency cannot meet this due date, it can request a 30 calendar day extension for submission. This request must be made in writing and received by MAD prior to the original due date.

(b) Failure to submit a cost report by the due date or the extended due date, when applicable, will result in suspension of all MAD payments until the cost report is received.

(4) Reimbursement rates for an ARTC out-of-state provider located more than 100 miles from the NM border (Mexico excluded) are at the fee schedule unless a separate rate is negotiated.

[8.321.2.12 NMAC - Rp, 8.321.2.11 NMAC, 12/10/2024]

8.321.2.13 APPLIED BEHAVIOR ANALYSIS (ABA):

MAD pays for medically necessary, empirically supported, applied behavior analysis (ABA) services for eligible recipients who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients who have well-documented risk for the development of ASD. As part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment, ABA services may be provided in coordination with other medically necessary services including but not limited to family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, and developmental disability waiver services. ABA services are part of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57) for recipients under the age of 21. There is no age requirement to receive ABA services and ABA is a covered benefit for medicaid enrolled adults.

A. Coverage Criteria:

(1) Confirmation of the presence or risk of ASD must occur through an approved autism evaluation provider (AEP) through a comprehensive diagnostic evaluation (CDE) used to determine the presence of and a diagnosis of ASD. A targeted evaluation is used when the eligible recipient who has a full diagnosis of ASD presents with behaviors that are changed from the last CDE. An ASD risk evaluation is used when an eligible recipient meets the at-risk criteria found in Subsection C of 8.321.2.13 NMAC.

(2) An integrated service plan (ISP) must be developed by the AEP together with a referral to an approved ABA provider agency (stage one).

(3) The ABA provider agency completes a behavior or functional analytic assessment. The assessment results determine if a focused or comprehensive model is selected and a treatment plan is completed (stage two).

(4) ABA stage two and three services are rendered by a behavior analyst certification board (BACB) approved behavior analyst (BA), a board certified assistant behavior analyst (BCaBA) or a behavior technician (BT), in accordance with the treatment plan (stage three). A BCaBA is referred to 8.321.2 NMAC as a behavior analyst assistant (BAA).

B. Eligible providers: ABA services are rendered by providers and practitioners who meet the qualification requirements: an AEP; a behavior analyst (BA) and a behavior technician (BT) through an ABA provider agency; and an ABA specialty care provider. Each ABA provider and practitioner has corresponding enrollment requirements and renders services according to their provider type and specialty. All providers must successfully complete a criminal background registry check. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) Stage 1: Autism evaluation provider (AEP): Completes the CDE, ASD risk evaluation or targeted evaluation and develops the ISP for an eligible recipient.

(2) Behavior analyst (BA): a BA who is a board certified behavior analyst (BCBA® or BCBA-D®) by the behavior analyst certification board (BACB®) or a psychologist who is certified by the American board of professional psychology in behavior and cognitive psychology and who was tested in the ABA part of their certification, may render ABA stage two-behavior analytic assessment, service model determination and treatment plan development and stage three services-implementation of an ABA treatment plan.

(3) Stage two and three BAA: A BAA who is a board certified assistant behavior analyst (BCaBA®) by the BACB® may assist their supervising BA in rendering a ABA stage two-behavior or functional analytic assessment, service model determination and ABA treatment plans development and stage three services implementation of the ABA treatment plans, when the BAA's supervising BA determines they have the skills and knowledge to render such services. This is determined in the contract the BAA has agreed to with their supervising BA.

(4) Stage three behavioral technician (BT): A BT, under supervision of a BA, may assist stage two and implement stage three ABA treatment plan interventions and services.

(5) Stage three ABA specialty care provider eligibility requirements: practitioners who are enrolled as BAs must provide additional documentation that demonstrates the practitioner has the skills, training and clinical experience to oversee and render ABA services to highly complex eligible recipients who require specialized ABA services.

(6) Additional provider types: To avoid a delay in receiving stage two services and three services, a recipient may be referred for ABA services with a presumptive diagnosis of ASD by a licensed practitioner whose scope of practice allows them to render a diagnosis of ASD. This diagnosis must have been received within three years of referral to stage two or three services.

C. Identified population: The admission criteria are separated into two types: at-risk for ASD and diagnosed with ASD.

(1) At-risk for ASD: an eligible recipient may be considered at risk for ASD if they do not meet full criteria for ASD per the latest version of the diagnostic statistical manual (DSM) or international classification of diseases (ICD). To be qualified for the ABA criteria of at-risk, the eligible recipient must meet all the following requirements:

(a) is between 12 and 36 months of age;

(b) presents with developmental differences and delays as measured by standardized assessments;

(c) demonstrates some characteristics of the disorder including but not limited to impairment in social communication and early indicators for the development of restricted and repetitive behavior; and

(d) presents with at least one genetic risk factor such as having an older sibling with a well-documented ASD diagnosis or eligible recipient has a diagnosis of Fragile X syndrome.

(2) Diagnosed with ASD: an eligible recipient who has a documented medical diagnosis of ASD according to the latest version of the DSM or the ICD is eligible for ABA services if they present with a CDE or targeted evaluation.

D. Covered services:

(1) Stage one: An eligible recipient is referred to an AEP after screening positive for ASD. The AEP conducts a diagnostic evaluation (CDE or targeted evaluation), develops the ISP, and recommends ABA stage two services. For an eligible recipient who has an existing ASD diagnosis, diagnostic re-evaluation is not necessary, but the development of an ISP and the determination of the medical necessity for ABA services are required.

(2) Stage two BA: For all eligible recipients, stage two services include a behavior or functional analytic assessment, ABA service model determination, and treatment plan development. The family, eligible recipient (as appropriate for age and developmental level), and the ABA provider's supervising BA work collaboratively to make a final determination regarding the clinically appropriate ABA service model, with consultative input from the AEP as needed. A behavior or functional analytic assessment addressing needs associated with both skill acquisition and behavior reduction is conducted, and an individualized ABA treatment plan, as appropriate for the ABA service model, is developed by the supervising BA. The BA is responsible for completing all of the following services:

(a) the recipient's assessment;

(b) selection and measurement of goals; and

(c) treatment plan formulation and documentation.

(3) Stage three - treatment: Most ABA stage three services require prior authorization and may vary in terms of intensity, frequency and duration, the complexity and range of treatment goals, and the extent of direct treatment provided.

(4) Stage three - clinical management and case supervision: All stage three services require clinical management. If a BAA or a BT is implementing the treatment plan, the BAA or BT requires case supervision from their BA or supervising BAA. The BH policy and billing manual provides a detailed description of the requirements for rendering clinical management and case supervision.

(5) Stage three - ABA specialty care services: Specialty care services require prior authorization. In cases where the needs of the eligible recipient exceed the expertise of the ABA provider and the logistical or practical ability of the ABA provider to fully support the eligible recipient MAD covers the eligible recipient for a referral to a MAD enrolled ABA specialty care practitioner (SCP).

(6) If the eligible recipient is in a residential facility or institutional setting that either specializes in or has as part of its treatment modalities ABA services, and the residential facility is not an ABA provider for ABA stage two and three services, and the eligible recipient has a CDE or targeted evaluation which recommends ABA stage two services, the residential facility is responsible to locate a MAD enrolled ABA stage two and three ABA provider and develop an agreement allowing the ABA provider to render stage two and three services at the residential facility. Reimbursement for ABA stage two and three services is made to the MAD enrolled ABA provider, not the residential facility.

(7) For an eligible recipient who meets the criteria for ABA services and who is in a treatment foster care (TFC) placement, they are not considered to be in a residential facility and may receive ABA services outside of the TFC agency. An eligible recipient who meets the criteria for ABA services who is in a residential treatment center, accredited residential treatment center, or a group home may receive ABA services to the extent that the residential provider is able to provide the services.

(8) See the BH policy and billing manual for specific instructions concerning stages one through three services.

E. Prior authorization - general information stage three services:

(1) Prior authorization to continue ABA stage three services must be secured every six months. At each six month authorization, a UR contractor will assess, with input from the family and ABA provider's BA, whether changes are needed in the eligible recipient's ISP or treatment plan. Additionally, the family or ABA provider may request ISP modifications prior to the UR contractor's six month authorization if immediate changes are warranted to preserve the health and wellbeing of the eligible recipient.

(2) To secure the initial and ongoing prior authorization for stage three services, the ABA provider must submit the prior authorization request, specifically noting:

(a) the CDE or targeted evaluation and the ISP from the AEP along with the ABA treatment plan;

(b) the requested treatment model (focused or comprehensive), maximum hours of service requested per week;

(c) the number of hours of case

supervision requested per week, if more than two hours of supervision per 10 hours of intervention is requested; the BH policy and billing manual provides detailed requirements for case supervision;

(d) the number of hours of clinical management requested per week, if more than two hours of clinical management per 10 hours of intervention is requested; and

(e) the need for collaboration with an ABA specialty care provider, if such a need has been identified through initial assessment and treatment planning; after services have begun, the ABA provider agency may refer the eligible recipient to a SCP for a focused behavior or functional analytic assessment focusing on the specific care needs of the eligible recipient. The SCP will then request a prior authorization for specialty care services from the UR contractor.

(3) The request must document hours allocated to other services including but not limited to early intervention through FIT, physical therapy, speech and language therapy that are in the eligible recipient's ISP in order for the UR contractor to determine if the requested intensity is feasible and appropriate.

(4) When an eligible recipient's behavior exceeds the expertise of the ABA provider and logistical or practical ability of the ABA provider to fully support them, MAD allows the ABA provider to request prior authorization for ABA specialty care services.

(5) Services may continue until the eligible recipient no longer meets service criteria for ABA services as described in the BH policy and billing manual.

(6) See the BH policy and billing manual for specific instructions on prior authorizations.

F. Non-covered services:

(1) The eligible recipient's comprehensive or targeted diagnostic evaluation or the ISP and treatment plan updates recommend placement in a higher, more intensive, or more restrictive level of care (LOC) and no longer recommends ABA services.

(2) Activities that are not designed to accomplish the objectives delineated in covered services and that are not included in the ABA treatment plan.

(3) Activities that are not based on the principles and application of applied behavior analysis.

(4) Activities that take place in school settings and have the potential to supplant educational services.

(5) Activities that are better described as another therapeutic service (e.g., speech language therapy, occupational therapy, physical therapy, counseling, etc.), even if the practitioner has expertise in the provision of ABA.

(6) Activities which are better characterized as staff training certification or licensure or certification supervision requirements, rather than ABA case supervision.

G. Reimbursement: Billing instructions for ABA services are detailed in the BH policy and billing manual.

[8.321.2.13 NMAC - Rp, 8.321.2.12 NMAC, 12/10/2024]

8.321.2.14 ASSERTIVE COMMUNITY TREATMENT SERVICES: To help an eligible recipient with medically necessary services MAD pays for covered assertive community treatment services (ACT). See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers:

(1) An ACT agency must demonstrate compliance with administrative, financial, clinical, quality improvement and information services infrastructure standards established by MAD or its designee, including compliance and outcomes consistent with the ACT fidelity model. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(2) An ACT agency providing coordinated specialty care for an individual with first episode psychosis must provide services consistent with the coordinated specialty care (CSC) model.

(3) ACT services must be provided by an agency designated team of 10 to 12 members; see Paragraph (5) of Subsection A of 8.321.2.14 NMAC for the required composition. A lower number of team member compositions may be considered by BHSD. The waiver request is dependent on the nature of the clinical severity and rural vs. urban environment pending BHSD approval. Each team must have a designated team leader. Practitioners on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; prescription, administration, monitoring and documentation of medications; substance use disorder treatment; work-related services; activities of daily living services; support services or direct assistance to ensure that the eligible recipient obtains the basic necessities of daily life; and coordination, support and consultation to the eligible recipient's family and other major supports. The agency must coordinate its ACT services with local hospitals, local crisis units, local law enforcement agencies, local behavioral health agencies, and consider referrals from social service agencies.

(4) Each ACT team staff member must be successfully and currently certified or trained according to ACT fidelity model standards. The training standards focus on developing staff competencies for delivering ACT services according to the most recent ACT evidenced-based practices and ACT fidelity model. Each ACT team shall have a sufficient number of qualified staff to provide treatment, rehabilitation, crisis and support

services 24-hours a day, seven days a week.

(5) Each ACT team shall have a staff-to eligible recipient ratio dependent on the nature of the team based on clinical severity and rural vs. urban environment pending BHSD approval to ensure fidelity with current model.

(6) Each ACT team must comply with 8.321.2.9 NMAC for specific licensing requirements for ACT staff team members as appropriate, and must include:

(a) one team leader who is an independently licensed behavioral health practitioner (LPCC, LMFT, LISW, LCSW, LPAT, psychologist);

(b) medical director/prescriber:

(i) board certified or board eligible psychiatrist; or

(ii) NM licensed psychiatric certified nurse practitioner; or

(iii) NM licensed psychiatric clinical nurse specialist; or

(iv) prescribing psychologist under the supervision or consultation of an MD; or

(c) two licensed nurses, one of whom shall be a RN, or other allied medical professionals may be used in place of one nurse;

(d) at least one other MAD recognized licensed behavioral health professional;

(e) at least one MAD enrolled licensed behavioral health practitioner with expertise in substance use disorders;

(f) at least one employment specialist;

(g) at least one NM certified peer support worker (CPSW) through the approved state of NM certification program; or certified family peer support worker (CFPSW);

(h) one administrative staff person; and

(i) the eligible recipient shall be considered a part of the team for decisions impacting their ACT services.

(7) The agency must have a HCA ACT approval letter to render ACT services to an eligible recipient. The approval letter will authorize an agency also delivering CSC model.

(8) Any adaptations to the model require an approved variance from BHSD.

B. Coverage criteria:

(1) MAD covers medically necessary ACT services required by the condition of the eligible recipient.

(2) The ACT program provides four levels of interaction with the participating individuals:

(a) face-to-face encounters.

(b) collateral encounters designated as members of the recipient's family or household, or significant others who regularly interact with the recipient and are directly affected by or have the capability of affecting their condition and are identified in the treatment plan as having a role in treatment.

(c) assertive outreach defined as the ACT team having knowledge of what is happening with an individual. This occurs in either locating the individual or acting quickly and decisively when action is called for, while increasing client independence. This is done on behalf of the client and can comprise only five percent per individual of total service time per month.

(d) Group encounters defined by the following types:

(i) basic living skills development;

(ii) psychosocial skills training;

(iii) peer groups; or

(iv) wellness and recovery groups.

(3) The ACT therapy model is based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan for the eligible recipient. Specialized therapeutic and rehabilitative interventions falling within the fidelity of the ACT model are used to address specific areas of need, such as experiences of repeated hospitalization or incarcerations, severe problems completing activities of daily living and individuals who have a significant history of involvement in behavioral health services.

C. Identified population:

(1) ACT services are provided to an eligible recipient aged 18 and older whose diagnosis or diagnoses meet the criteria of SMI with a special emphasis on psychiatric disorders, including schizophrenia, schizoaffective disorder, bipolar disorder or psychotic depression for individuals who have severe problems completing activities of daily living, who have a significant history of involvement in behavioral health services and who have experienced repeated hospitalizations or incarcerations due to mental illness.

(2) ACT services can also be provided to eligible individuals 15 to 30 years of age who are within the first two years of their first episode of psychosis.

(3) A co-occurring diagnosis of SUD shall not exclude an eligible recipient from ACT services.

D. Covered services: ACT is a voluntary medical, comprehensive case management and psychosocial intervention program. See the BH policy and billing manual for a complete service description.

E. Non-covered services: ACT services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for MAD general non-covered behavioral health services. MAD does not cover other

psychiatric, mental health nursing, therapeutic, non-intensive outpatient substance use disorder treatment or crisis services when billed in conjunction with ACT services to an eligible recipient, except for medically necessary medications and hospitalizations. Psychosocial rehabilitation and intensive outpatient services can be billed concurrently if indicated in treatment plan but must be identified as a component of the treatment plan.

F. Reimbursement: ACT agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 for MAD general reimbursement requirements. [8.321.2.14 NMAC - Rp, 8.321.2.13 NMAC, 12/10/2024]

8.321.2.15 BEHAVIORAL HEALTH PROFESSIONAL SERVICES FOR SCREENINGS, EVALUATIONS, ASSESSMENTS AND THERAPY: MAD covers validated screenings for high-risk conditions in order to provide prevention or early intervention. Brief interventions or the use of the treat first clinical model may be billed with a provisional diagnosis for up to four encounters. After four encounters, if continuing treatment is required, a diagnostic evaluation must be performed, and subsequent reimbursement is based on the diagnosis and resulting treatment plan. See the BH policy and billing manual for a description of the treat first clinical model.

A. Psychological, counseling, and social work: These services are diagnostic or active treatments with the intent to reasonably improve an eligible recipient's physical, social, emotional, and behavioral health, or substance use condition. Services are provided to an eligible recipient whose condition or functioning can be expected to improve with these interventions. Psychological, counseling, and social work services are performed by licensed psychological, counseling, and social work practitioners acting within their scope of practice and licensure (see Subsections B through E of 8.321.2.9 NMAC). These services include, but are not limited to assessments that appraise cognitive, emotional, and social functioning and self-concept. Therapy includes planning, managing, and providing a program of psychological services to the eligible recipient meeting a current DSM, ICD, or DC:0-5 behavioral health diagnosis and may include therapy with their family, parent or caretaker, and consultation with their family and other professional staff.

B. An assessment as described in the BH policy and billing manual, must be signed by the practitioner operating within their scope of licensure (see Subsection B of 8.321.2.9 NMAC). A non-independently licensed behavioral health practitioner must have an independently licensed RLD board approved supervisor review and sign the assessment with a diagnosis. Based on the eligible recipient's current assessment, their treatment file must document the extent to which their treatment goals are being met and whether changes in direction or emphasis of the treatment are needed. See Subsection K of 8.321.2.9 NMAC for detailed description of the required eligible recipient file documentation.

C. Outpatient therapy services (individual, family, and group) includes planning, managing, and providing a program of psychological services to the eligible recipient with a diagnosed behavioral health disorder, and may include consultation with their family and other professional staff with or without the eligible recipient present when the service is on behalf of the recipient. See the BH policy and billing manual for detailed requirements of treatment plans. [8.321.2.15 NMAC - Rp, 8.321.2.14 NMAC, 12/10/2024]

8.321.2.16 BEHAVIORAL HEALTH RESPITE CARE (Managed Care Organization (MCO)): As part of the managed care comprehensive service system, behavioral health respite service is for short-term direct care and supervision of the eligible recipient in order to afford the parent(s) or caregiver a respite for their care of the recipient and takes place in the recipient's home or another setting. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible practitioners:

(1) Supervisor:

(a) bachelor's degree and three years' experience working with the target population;

(b) supervision activities include a minimum of two hours per month individual supervision covering administrative and case specific issues, and two additional hours per month of continuing education in behavioral health respite care issues, or annualized respite provider training;

(c) access to on call crisis support available 24-hours a day; and

(d) supervision by RLD board approved clinical supervisors must be in accordance with their respective licensing board regulations.

(2) Respite care staff:

(a) minimum three years' experience working with the target population;

(b) pass all criminal records and background checks for all persons residing in the home over 18;

(c) possess a valid driver's license, vehicle registration and insurance, if transporting member;

(d) CPR and first aid; and

(e) documentation of behavioral health orientation, training and supervision as defined in the BH policy and billing manual.

B. Coverage criteria: The provider agency will assess the situation and, with the caregiver, recommend the appropriate setting

for respite. BH respite services may include a range of activities to meet the social, emotional and physical needs identified through the treatment plan and documented in the treatment record. These services may be provided for a few hours during the day or for longer periods of time involving overnight stays. BH respite, while usually planned, can also be provided in an emergency or unplanned basis.

C. Identified population:

(1) Members up to 21 years of age diagnosed with a severe emotional disturbance (SED), as defined by the state of NM who reside with the same primary caregivers on a daily basis; or

(2) Youth in protective services custody whose placement may be at risk whether or not they are diagnosed with SED.

D. Non-covered services:

(1) 30 days or 720 hours per year at which time prior authorization must be acquired for additional respite care;

(2) May not be billed in conjunction with the following medicaid services:

(a) treatment foster care;

(b) group home;

(c) residential services;

(d) inpatient treatment.

(3) Non-enrolled siblings of a child receiving BH respite services are not eligible for BH respite benefits; and

(4) Cost of room and board are not included as part of respite care.

[8.321.2.16 NMAC - Rp, 8.321.2.15 NMAC, 12/10/2024]

8.321.2.17 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES:

To help an eligible recipient under 21 years of age who is in need of behavior management intervention receive services, MAD pays for behavior management services (BMS) as part of the EPSDT program and when the need for BMS is identified in a tot to teen health check screen or other diagnostic evaluation (see 42 CFR Section 441.57). BMS services are designed to provide highly supportive and structured therapeutic behavioral interventions to maintain the eligible recipient in their home or community. BMS assists in reducing or preventing inpatient hospitalizations or out-of-home residential placement of the eligible recipient through use of teaching, training and coaching activities designed to assist them in acquiring, enhancing, and maintaining the life, social and behavioral skills needed to function successfully within their home and community settings. BMS is provided as part of a comprehensive approach to treatment and in conjunction with other services as indicated in the eligible recipient's comprehensive behavioral health treatment plan. BMS is not provided as a stand-alone service but delivered as part of an integrated plan of services to maintain eligible recipients in their communities as an alternative to out-of-home services.

A. Eligible providers: An agency must be certified by CYFD to provide BMS services per 7.20.11 NMAC. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

B. Coverage criteria: MAD reimburses for behavior management services specified in the eligible recipient's individualized treatment plan which are designed to improve their performance in targeted behaviors, reduce emotional and behavioral episodic events, increase social skills, and enhance behavioral skills through a regimen of positive intervention and reinforcement.

(1) Implementation of the eligible recipient's BMS treatment plan, which includes crisis planning, must be based on a clinical assessment that includes identification of skills deficits that will benefit from an integrated program of therapeutic services. A detailed description of required elements of the assessment and treatment plan are found in the BH policy and billing manual.

(2) 24-hour availability of appropriate staff or implementation of crisis plan, which may include referral, to respond to the eligible recipient's crisis situations.

(3) Supervision of behavioral management staff by an independent level practitioner is required for this service (8.321.2.9 NMAC). Policies governing supervisory responsibilities are detailed in the BH policy and billing manual. The supervisor must ensure that:

(a) a clinical assessment of the eligible recipient is completed upon admission into BMS. The clinical assessment identifies the need for BMS as medically necessary to prevent inpatient hospitalizations or out-of-home residential placement of the eligible recipient;

(b) the assessment is signed by the recipient or their parent or legal guardian; and

(c) the BMS worker receives documented supervision for a minimum of two hours per month dependent on the complexity of the needs presented by recipients and the supervisory needs of the BMS worker.

(4) An eligible recipient's treatment plan must be reviewed at least every 30 calendar days after implementation of the comprehensive treatment plan. The BMS, in partnership with the client and family as well as all other relevant treatment team members such as school personnel, juvenile probation officer (JPO), and guardian ad litem (GAL), shall discuss progress made over time relating to the BMS service goals. If the BMS treatment team assesses the recipient's lack of progress over the last 30 days, the treatment plan will be amended as agreed upon during the treatment team meeting. Revised BMS treatment plans will be reviewed and approved by the BMS supervisor, which must be documented in the recipient's file.

C. Identified population: In order to receive BMS services, an eligible recipient must be under the age of 21 years, be diagnosed with a behavioral health condition and:

(1) be at-risk for out-of-home residential placement due to unmanageable behavior at home or within the community;

(2) need behavior management intervention to avoid inpatient hospitalizations or residential treatment; or

(3) require behavior management support following an institutional or other out-of-home placement as a transition to maintain the eligible recipient in their home and community.

(4) either the need for BMS is not listed on an individualized education plan (IEP), or it is listed in the supplementary aid and service section of the IEP.

D. Non-covered services: BMS services are subject to the limitations and coverage restrictions which exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with BMS services:

(1) activities which are not designed to accomplish the objectives in the BMS treatment plan;

(2) services provided in residential treatment facilities; and

(3) services provided in lieu of services that should be provided as part of the eligible recipient's individual educational plan (IEP) or individual family treatment plan (IFTP).

(4) BMS is not a reimbursable service through the medicaid school-based service program.

E. Reimbursement: A BMS agency must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. [8.321.2.17 NMAC - Rp, 8.321.2.16 NMAC, 12/10/2024]

8.321.2.18 COGNITIVE ENHANCEMENT THERAPY (CET): CET services provide treatment service for an eligible recipient 18 years of age or older with cognitive impairment associated with the following serious mental illnesses: schizophrenia, bipolar disorder, major depression, recurrent schizoaffective disorder, or autism spectrum disorder. CET uses an evidence-based model to help eligible recipients with these conditions improve their processing speed, cognition, and social cognition. Any CET program must be approved by the BHSD and ensure that treatment is delivered with fidelity to the evidence-based model.

A. Eligible providers: Services may only be delivered through a MAD enrolled provider after demonstrating that the agency meets all the requirements of CET program services and supervision. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) CET services are provided through an integrated interdisciplinary approach by staff with expertise in the mental health condition being addressed and have received training from a state approved trainer. Staff can include independently licensed behavioral health practitioners, non-independently licensed behavioral health practitioners, RNs, or CSWs. For every CET cohort of eligible recipients, there must be two practitioners who have been certified in the evidence-based practice by a state approved trainer or training center. The agency shall retain documentation of the staff that has been trained. The size of each cohort who receives CET must conform to the evidence-based practice (EBP) model in use.

(2) The agency must hold an approval letter issued by BHSD certifying that the staff have participated in an approved training or have arranged to participate in training and have supervision by an approved trainer prior to commencing services.

(3) Weekly required participation in hourly fidelity monitoring sessions with a certified CET trainer for all providers delivering CET who have not yet received certification.

B. Covered services:

(1) CET services include:

(a) weekly social cognition groups with enrollment according to model fidelity;

(b) weekly computer skills groups with enrollment according to model fidelity;

(c) weekly individual face-to-face coaching sessions to clarify questions and to work on homework assignments;

(d) initial and final standardized assessments to quantify social-cognitive impairment, processing speed, cognitive style; and

(e) individual treatment planning.

(2) The duration of an eligible recipient's CET intervention is based on model fidelity. Each individual participating in CET receives up to three hours of group treatment and up to one hour of individual face-to-face coaching.

C. Identified population: CET services are provided to an eligible adult recipient 18 years of age and older with cognitive impairment associated with the following serious mental illnesses:

(1) schizophrenia;

(2) bipolar disorder;

(3) major depression, recurrent;

(4) schizoaffective disorder; or

(5) autism spectrum disorder.

D. Non-covered services:

(1) CET services are subject to the limitation and coverage restrictions which exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services.

(2) MAD does not cover the CET during an acute inpatient stay.

E. Reimbursement: See Subsection H of 8.321.2.9 NMAC for MAD behavioral health general reimbursement.

(1) For CET services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor.

(2) Core CET services are reimbursed through a bundled rate. Medications and other mental health therapies are billed and reimbursed separately from the bundled rate.

(3) CET services furnished by a CET team member are billed by and reimbursed to a MAD enrolled CET agency whether the team member is under contract with or employed by the CET agency.

(4) CET services not provided in accordance with the conditions for coverage as specified in 8.321.2.9 NMAC are not a MAD covered service and are subject to recoupments.

(5) Billing instructions for CET services are detailed in the BH policy and billing manual.

[8.321.2.18 NMAC - Rp, 8.321.2.17 NMAC, 12/10/2024]

8.321.2.19 COMPREHENSIVECOMMUNITY SUPPORT SERVICES (CCSS): To help a NM eligible recipient receive medically necessary services, MAD pays for covered CCSS. This culturally sensitive service coordinates and provides services and resources to an eligible recipient and their family necessary to promote recovery, rehabilitation, and resiliency. CCSS identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the eligible recipient's community, as well as strengths that may aid the eligible recipient and family in the recovery or resiliency process.

A. Eligible providers and practitioners:

(1) See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements. To provide CCSS services, a provider must receive CCSS training through the state or state approved trainer. The children, youth and families department (CYFD) will provide background checks for CCSS direct service and clinical staff for child/youth CCSS programs.

(2) Clinical services and supervision by licensed behavioral health practitioners must be in accord with their respective licensing board regulations:

(a) minimum staff qualifications for the community support worker (CSW):

(i) must be at least 18 years of age; and

(ii) hold a bachelor's degree in a human services field from an accredited university and have one year of relevant experience with the target population; or

(iii) hold an associate's degree and a minimum of two years of experience working with the target population; or

(iv) hold an associate's degree in approved curriculum in behavioral health coaching; no experience necessary; or

(v) have a high school diploma or equivalent and a minimum of three years of experience working with the target population; or

(vi) hold a valid certification in good standing from the NM credentialing board as a certified peer support worker (CPSW), a certified family peer support worker (CFPSW) or a certified youth peer support specialist (CYPSS); and

(b) minimum staff qualifications for certified peer support workers:

(i) must hold a valid certification in good standing from the NM credentialing board for behavioral health professionals; and

(ii) meet all qualifications defined in 8.321.2.42 NMAC.

(b) minimum staff qualifications for the CCSS program supervisor:

(i) must hold a bachelor's degree in a human services field from an accredited university; and

(ii) have four years relevant experience in the delivery of case management or CCSS with the target population; and

(iii) have one year demonstrated supervisory experience.

(c) minimum staff qualifications for the clinical supervisor:

(i) must be RLD board approved clinical supervisor;

(ii) provide documented clinical supervision on a regular basis to the CSW, CPSW, CFPSW, and CYPSS; and

(iii) obtain a continuing education unit (CEU) training certificate related to providing clinical supervision of non-clinical staff.

(3) The clinical supervisor and the CCSS program supervisor may be the same individual.

(4) Documentation requirements: In addition to the standard client record documentation requirements for all services, the following is required for CCSS:

(a) case notes identifying all activities and location of services;

(b) duration of service span; and

(c) description of the service provided

with reference to the CCSS treatment plan and related goals.

B. Coverage criteria:

(1) CCSS must be identified in the treatment plan for an individual. When identifying a need for this service, if the provider agency is using the "treat frst" clinical model, they may be placed in this service for up to four encounters without having had a psychiatric diagnostic evaluation with the utilization of a provisional diagnosis for billing purposes. After four encounters, an individual must have a comprehensive needs assessment, a diagnostic evaluation, and a CCSS treatment plan. Further details related to the CCSS treatment plan can be accessed in the BH policy and billing manual.

(2) A maximum of 16 units per each admission or discharge may be billed concurrently with:

(a) accredited residential treatment center (ARTC);

(b) adult accredited residential treatment center (AARTC);

(c) residential treatment center (RTC);

(d) group home service;

(e) inpatient hospitalization; or

(f) treatment foster care (TFC).

C. Covered services: The purpose of CCSS is to provide an eligible recipient and their family with the services and resources necessary to promote recovery, rehabilitation, and resiliency. Community support services address goals specifically in the following areas of the eligible recipient's activities: independent living; learning; working; socializing and recreation. CCSS consists of a variety of interventions, based on coaching and addressing barriers that impeded the development of skills necessary for independent functioning in the community. Community support services also include assistance with identifying and coordinating services and supports identified in an individual's treatment plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.

D. Identified population:

(1) CCSS is provided to an eligible recipient under 21 years who meets the NM state criteria for SED/neurobiological/ behavioral disorders; and

(2) CCSS is provided to an eligible recipient 21 years and older whose diagnosis or diagnoses meet the NM state criteria of SMI and for an eligible recipient with a diagnosis that does not meet the criteria for SMI, but for whom time limited CCSS would support their recovery and resiliency process; and

(3) Recipients with a moderate to severe SUD according to the current DSMV or its successor; and

(4) Recipients with a co-occurring disorder or dually diagnosed with a primary diagnosis of mental illness.

E. Non-covered services: CCSS is subject to the limitations and coverage restrictions which exist for other MAD covered services. See 8.310.2 NMAC for a detailed description of MAD general non-covered services and subsection G of 8.321.2.9 NMAC for all non-covered MAD behavioral health services or activities. Specifically, CCSS may not be billed in conjunction with multi-systemic therapy (MST) or ACT services, or resource development by New Mexico corrections department (NMCD).

F. Reimbursement: CCSS agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor; see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing information. General reimbursement instructions are found in this rule under Subsection H of 8.321.2.9 NMAC. Billing instructions for CCSS are found in the BH policy and billing manual.

[8.321.2.19 NMAC - Rp, 8.321.2.18 NMAC, 12/10/2024]

8.321.2.20 CRISIS INTERVENTION SERVICES: MAD pays for a continuum of community-based crisis intervention services which are immediate, and designed to ameliorate, prevent, or minimize a crisis episode or to prevent inpatient psychiatric hospitalization, medical detoxification, emergency department use, multiple system involvement or incarceration. Services are provided to eligible recipients who are unable to use their current coping strategies and need immediate support. Crisis intervention services include telephone crisis services; face-to-face crisis triage and intervention; mobile crisis services; and crisis stabilization services.

A. Coverage criteria:

(1) Telephone crisis services:

(a) agencies providing telephone crisis services must develop policy and procedures regarding telephone crisis services which must be made available to MAD or is designee upon request;

(b) assurance that a backup crisis telephone system is available if the toll-free number is not accessible;

(c) assurance that calls are answered by a person trained in crisis response as described in the BH policy and billing manual;

(d) processes to screen calls, evaluate crisis situation, provide referral to mobile crisis team (MCT) or mobile response and stabilization services (MRSS) when appropriate, and provide counseling and consultation to crisis callers are documented and implemented;

(e) assurance that face-to-face intervention services are available

immediately if clinically indicated either by the telephone service or through memorandums of understanding with referral sources;

(f) provision of a toll-free number, such as 988, and the agency's number to active clients and their support; and

(g) documentation of each phone call must be maintained and include:

(i) date, time and duration of call;

(ii) name of individual calling;

(iii) responder handling call;

(iv) description of crisis; and

(v) intervention provided, (e.g. counseling, consultation, referral, etc.).

(2) Face-to-face clinic crisis services:

(a) the provider shall make an immediate assessment for purposes of developing a system of triage to determine urgent or emergent needs of the person in crisis. This may include a referral to MCT or MRSS when appropriate. (Note: The immediate assessment may have already been completed as part of a telephone crisis response.)

(b) within the first two hours of the crisis event, the provider will initiate the following activities:

(i) immediately conduct the crisis assessment;

(ii) protect the individual (possibly others) and de-escalate the situation;

(iii) determine if a higher level of service or other supports are required and arrange, if applicable; and

(iv) develop or update the crisis and safety plans.

(c) follow-up: initiate telephone call or face-to-face follow up contact with individual within 24 hours of initial crisis.

(3) Mobile crisis intervention services:

(a) mobile crisis services provide rapid response, individual assessment, and evaluation and treatment of mental health crisis to individuals experiencing a mental health crisis or SUD crisis. A crisis is defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow mobile crisis services:

(i) are provided in two models: MCT and MRSS. MRSS is a child, youth and family specific crisis intervention and prevention service. In order to be eligible to provide services MCT and MRSS teams must be approved though the application process outlined in the BH policy and billing manual;

(ii) must be provided by a multidisciplinary team of at least two behavioral health professionals or paraprofessionals, as defined in 8.321.2.9 NMAC, that includes at minimum a RLD board approved clinical supervisor who must be available to provide real-time clinical assessment and clinical support in-person or via telehealth at any time during the initial response;

(iii) must be available where the individual is experiencing a mental health, or SUD, crisis and may not be restricted to a specific location and in the least restrictive environment available;

(iv) must be available 24 hours a day, seven days a week and 365 days per year and may not be restricted to select days or times;

(v) must be person and family centered as well as culturally, linguistically, and developmentally appropriate;

(vi) may be provided prior to an intake evaluation for mental health services; and

(vii) may not be provided in a hospital or other facility setting.

(b) at a minimum, mobile crisis services including initial response of conducting immediate crisis screening an assessment, mobile crisis stabilization and de-escalation, and coordination with and referral to health social and other services as needed to effect symptom reduction, harm reduction or to safely transition an individual in acute crisis to the appropriate environment for continued stabilization. MCT and MRSS teams must:

(i) be trained in trauma-informed care, de-escalation strategies, and harm reduction;

(ii) be able to respond in a timely manner;

(iii) have the ability to provide screening and assessment, stabilization and de-escalation, and coordination and referral to services as appropriate;

(iv) ensure language access for individuals with limited-English proficiency, those who are deaf or hard of hearing, and comply with all applicable requirements under the Americans with Disabilities Act, Rehabilitation Act, and Civil Rights Act;

(v) maintain relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations for the purpose of coordination and referral to services; and

(vi) be able to administer naloxone.

(c) MCTs and MRSS may connect individuals to facility-based care as needed, through warm hand-offs and coordinating transportation only in situations that warrant transition to other locations or higher levels of care. Services may also include telephone follow-up or intervention services for up to 72 hours after the

initial mobile response. Follow-up may include additional intervention and de-escalation services as well as referral to care as appropriate.

(4) Mobile response and stabilization services (MRSS):

(a) MRSS must comply with requirements outlined in Paragraph (3) of Subsection A of 8.321.2.19 NMAC as well as the meet the following criteria:

(i) provider response and stabilization services to individuals 0-21 years of age;

(ii) provide immediate, in-person, response to de-escalate crisis or safety and stability event that is defined by the family. A safety and stability event is defined as the perception of an event or situation as an intolerable difficulty that exceeds the resources and coping mechanisms of the caregiver; an unexpected or out of control event that causes pain, suffering, or instability for the family; an event occurs that could result in movement to a higher level of care or a restrictive setting; or the caregiver does not know what to do about a child's behavior; and

(iii) provide up to 56 days of stabilization service support, follow-up and navigation to reduce the likelihood of future crisis or out of home placement.

(b) MRSS aligns with the children's system of care (SOC) approach in NM. MRSS supports teams to effectively coordinate within the state's children's behavioral health service array including access to community support and resources.

(5) Crisis stabilization services: Outpatient, clinic-based, stabilization services for substance use and co-occurring disorder crises which includes ASAM level two withdrawal management. Crisis stabilization services include assessment, safety planning and coordination with appropriate resources for up to 24 hours. This service is available across the lifespan.

B. Eligible practitioners:

(1) Telephone crisis services:

(a) individual crisis workers who are covering the crisis telephone must meet the following criteria:

(i) CPSW with one year work experience with individuals with behavioral health condition;

(ii) bachelor level community support worker employed by the agency with one year work experience with individuals with a behavioral health condition;

(iii) RN with one year work experience with individuals with behavioral health condition;

(iv) LMHC with one year work experience with individuals with behavioral health condition;

(v) LMSW with one year work experience with individuals with behavioral health condition; or

(vi) psychiatric physician assistant;

(vii) LADAC; or

(viii) LSAA with one year of work experience with individuals with behavioral health conditions.

(b) Supervision by a:

(i) psychiatrist; or

(ii) RLD board approved clinical supervisor.

(c) training:

(i) 20 hours of crisis intervention training that addresses the developmental needs of the full age span of the target population by a licensed independent mental health professional with two years crisis work experience; and

(ii) 10 hours of crisis related continuing education annually.

(2) Mobile crisis intervention services for MCT and MRSS:

(a) services must be delivered by an agency designated as an MCT or MRSS through the approval process defined in the BH policy and billing manual and must be an enrolled medicaid provider. Allowable agency types are identified in Subsection D of 8.321.2.9 NMAC.

(b) services must be delivered by a minimum of a two-person team that includes at minimum a RLD board approved clinical supervisor who must be available to provide real-time clinical assessment and clinical support in-person or via telehealth;

(c) additional team members may include:

(i) a licensed mental health therapist;

(ii) certified peer support worker;

(iii) certified family peer support worker;

(iv) certified youth peer support specialist;

(v) community support worker;

(vi) community health worker;

(vii) community health representative;

(viii) certified prevention specialist;

(ix) registered nurse;

(x) emergency medical service provider;

(xi) licensed alcohol and drug abuse counselor (LADAC);

(xii) non-independently licensed behavioral health professionals as defined in 8.321.2.9 NMAC.

(xiii) emergency medical technicians;

(xiv) licensed practical nurses;

(xv) other certified or credentialed individuals;

(xvi) tribal 638 or IHS facilities may request a waiver to the staffing requirements outlined above for MRSS by submitting a staffing plan to the department as defined in the BH billing and policy manual.

(3) Crisis stabilization services: staffing must include RLD board approved clinical supervisor and:

(a) one registered nurse (RN) licensed by the NM board of nursing with experience or training in crisis triage and managing intoxication and withdrawal management when providing ASAM level two detoxification services;

(b) one regulation and licensing department (RLD) master's level licensed mental health professional on-site during all hours of operation;

(c) certified peer support worker, certified family per support worker, or certified youth peer support worker, on-site or available for on-call response during all hours of operation; and

(d) board certified physician or certified nurse practitioner licensed by the NM board of nursing either on-site or on call.

C. Covered services:

(1) Telephone crisis services:

(a) the screening of calls, evaluation of the crisis situation and provision of counseling and consultation to the crisis callers.

(b) referrals to appropriate mental health professions, where applicable.

(c) maintenance of telephone crisis communication until a face-to-face response occurs, as applicable.

(2) Face-to-face clinic crisis services:

(a) crisis assessment;

(b) other screening, as indicated by assessment;

(c) brief intervention or counseling; and

(d) referral to needed resource.

(3) Mobile crisis intervention services:

(a) immediate crisis screening and assessment;

(b) other screening, as indicated by assessment;

(c) mobile crisis stabilization and de-escalation and crisis prevention activities specific to the needs of the individual;

(d) coordination with and referral to health, social, and other service as needed to effect symptom reduction harm reduction or to safely transition person in acute crisis to the appropriate environment for continued stabilization;

(e) warm hand off and coordination of transportation in situations that warrant transition to other locations; and

(f) telephonic follow-up interventions for up to 72 hours after the initial mobile response. Follow-up may include additional intervention and de-escalation services as well as referral to care as appropriate.

(4) Mobile crisis intervention services for MRSS: includes all mobile crisis intervention defined in Paragraph (3) of Subsection C of 8.321.2.19 and up to 56 days of stabilization services.

(5) Crisis stabilization services:

(a) ambulatory withdrawal management includes:

(i) evaluation, withdrawal management and referral services under a defined set of physician approved policies and clinical protocols. The physician does not have to be on-site, but available during all hours of operation;

(ii) clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems;

(iii) comprehensive medical history and physical examination of recipient at admission;

(iv) psychological and psychiatric consultation;

(v) conducting or arranging for appropriate laboratory and toxicology test;

(vi) assistance in accessing transportation services for recipients who lack safe transportation.

(b) crisis stabilization includes but is not limited to:

(i) crisis triage that involves making crucial determinations within several minutes about an individual's course of treatment;

(ii) screening and assessment;

(iii) de-escalation and stabilization;

(iv) brief intervention or psychological counseling;

(v) peer support; and

(vi) prescribing and administering medication, if applicable.

(c) navigational services to support individuals in the community include assistance with:

(i) prescription and medication assistance;

(ii) arranging for temporary or permanent housing;

(iii) family or caregiver and natural support group planning;

(iv) outpatient behavioral health referrals and appointments; and

(v) other services determined through the assessment process.

D. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See

the BH policy and billing manual for reimbursement specific to crisis intervention services.
[8.321.2.20 NMAC - Rp, 8.321.2.19 NMAC, 12/10/2024]

8.321.2.21 CRISIS TRIAGE CENTER: MAD pays for a set of services, either outpatient or residential, to eligible adults and youth 14 years of age and older, to provide voluntary and involuntary stabilization of behavioral health crises including emergency mental health evaluation and care. Crisis triage centers (CTC) shall provide emergency screening and evaluation services 24-hours a day, seven days a week. Involuntary admissions are for individuals who have been determined to be a danger themselves or others and are governed by the requirements of the New Mexico mental health and developmental disabilities code, 43-1-1 through 43-1-21 NMSA 1978.

A. Coverage criteria for CTCs which include residential care:

(1) The CTC shall provide emergency screening, and evaluation services 24-hours a day, seven days a week and shall admit 24-hours a day seven days a week and discharge seven days a week;

(2) Readiness for discharge shall be reviewed in collaboration with the recipient every day;

(3) An independently licensed mental health practitioner or non-independent mental health practitioner under the supervision of RLD board-approved clinical supervisor must assess each individual with the assessment focusing on the stabilization needs of the client;

(4) The assessment must include medical and mental health history and status, the onset of the illness, the presenting circumstances, risk assessment, cognitive abilities, communication abilities, social history and history of trauma;

(5) A licensed mental health professional must document a crisis stabilization plan to address needs identified in the assessment which must also include criteria describing evidence of stabilization and either transfer or discharge criteria;

(6) The CTC identifies recipients at high risk of suicide or intentional self-harm, and subsequently engages these recipients through solution-focused and harm-reducing methods;

(7) Education and program offerings are designed to meet the stabilization and transfer of recipients to a different level of care;

(8) The charge nurse, in collaboration with a behavioral health practitioner, shall make the determination as to the time and manner of transfer to ensure no further deterioration of the recipient during the transfer between facilities, and shall specify the benefits expected from the transfer in the recipient's record;

(9) The facility shall develop policies and procedures addressing risk assessment and mitigation including, but not limited to: assessments, crisis intervention plans, treatment, approaches to supporting, engaging and problem solving, staffing, levels of observation and documentation. The policies and procedures must prohibit seclusion and address physical restraint, if used, and the facility's response to clients that present with imminent risk to self or others, assaultive and other high-risk behaviors;

(10) Use of seclusion is prohibited;

(11) The use of physical restraint must be consistent with federal and state laws and regulation;

(12) Physical restraint, as defined in the BH policy and billing manual, shall be used only as an emergency safety intervention of last resort to ensure the physical safety of the client and others, and shall be used only after less intrusive or restrictive interventions have been determined to be ineffective;

(13) If serving both youth and adult populations, the service areas must be separate; and

(14) If an on-site laboratory is part of services, the appropriate clinical laboratory improvement amendments (CLIA) license must be obtained.

B. Coverage criteria for CTCs which are outpatient only: Paragraph (3) through (14) of Subsection A of 8.321.2.21 NMAC are conditions of coverage for outpatient only services.

C. Eligible providers and practitioners:

(1) A provider agency licensed through the department of health as a crisis triage center offering one of the following types of service:

(a) a CTC structured for less than 24-hour stays providing only outpatient withdrawal management or other stabilization services;

(b) a CTC providing outpatient and residential crisis stabilization services; or

(c) a CTC providing residential crisis stabilization services.

(2) Practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery.

(3) All providers must be licensed in NM for services performed in NM. For services performed by providers licensed outside of NM, a provider's out-of-state license may be accepted in lieu of licensure in NM if the out-of-state licensure requirements are similar to those of the state of NM.

(4) For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

(5) The facility shall maintain sufficient staff including supervision and direct care and mental health professionals to provide for the care of residential and non-residential clients served by the facility, based on the acuity of client needs.

(6) The following individuals and practitioners, working within the scope of their licensure, must be contracted or employed by the provider agency as part of its crisis triage center service delivery:

(a) an on-site administrator which can be the same person as the clinical director. The administrator is specifically assigned to crisis triage center service oversight and administrative responsibilities and:

(i) is experienced in acute mental health; and

(ii) is at least 21 years of age; and

(iii) holds a minimum of a bachelor's degree in the human services field; or

(iv) is a registered nurse (RN) licensed by the NM board of nursing with experience or training in acute mental health treatment.

(b) a full time clinical director that is:

(i) at least 21 years of age; and

(ii) is a licensed independent mental health practitioner or certified nurse practitioner or clinical nurse specialist with experience and training in acute mental health treatment and withdrawal management services if withdrawal management services are provided.

(c) a charge nurse on duty during all hours of operation under whom all services are directed, with the exception of services provided by the physician and the licensed independent mental health practitioner, and who is:

(i) at least 18 years of age; and

(ii) a RN licensed by the NM board of nursing with experience in acute mental health treatment and withdrawal management services, if withdrawal management services are provided. This requirement may be met through access to a supervising nurse who is available via telehealth.

(d) a regulation and licensing department (RLD) master's level licensed mental health practitioner;

(e) certified peer support workers (CPSW) holding a certification by the NM credentialing board for behavioral health professionals as a certified peer support worker staffed appropriate to meet the client needs 24 hours a day seven days a week;

(f) an on-call physician during all hours of operation who is a physician licensed to practice medicine (MD) or osteopathy (DO), or a licensed certified nurse practitioner (CNP), or a licensed clinical nurse specialist (CNS) with behavioral health experience as described in 8.310.3 NMAC;

(g) a part time psychiatric consultant or prescribing psychologist, hours determined by size of center, who is a physician (MD or DO) licensed by the board of medical examiners or board of osteopathy and is board eligible or board certified in psychiatry as described in 8.321.2 NMAC, or a prescribing psychologist licensed by the board of psychologist examiners or psychiatric certified nurse practitioner as licensed by the board of nursing. These services may be provided through telehealth;

(h) at least one staff trained in basic cardiac life support (BCLS), the use of the automated external defibrillator (AED) equipment, and first aid shall be on duty at all times.

(7) Additional staff may include an emergency medical technician (EMT) with documentation of three hours of annual training in suicide risk assessment.

D. Identified population:

(1) An eligible recipient is 18 years of age and older who meets the crisis triage center admission criteria if the CTC is an adult only agency.

(2) If serving youth, an eligible recipient is 14 years through 17 years.

(3) Recipients may also have other co-occurring diagnoses.

(4) The CTC shall not refuse service to any recipient who meets the agency's criteria for services, or solely based on the recipient being on a law enforcement hold or living in the community on a court ordered conditional release.

E. Covered services:

(1) Comprehensive medical history and physical examination of recipient at admission;

(2) Development and update of the assessment and plan as described in the BH policy and billing manual;

(3) Crisis stabilization including, but not limited to:

(a) crisis triage that involves making crucial determinations within several minutes about an individual's course of treatment;

(b) screening and assessment as described in the BH policy and billing manual;

(c) de-escalation and stabilization;

(d) brief intervention and psychological counseling;

(e) peer support.

(4) Ambulatory withdrawal management (non-residential) based on American society of addiction medicine (ASAM) 2.1 level of care includes:

(a) evaluation, withdrawal management and referral services under a defined set of physician approved policies and clinical protocols;

(b) clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems;

(c) psychological and psychiatric consultation; and

(d) other services determined through the assessment process.

(5) Clinically or medically monitored withdrawal management in residential setting, if included, not to exceed services described in level 3.7 of the current ASAM patient placement criteria.

(6) Prescribing and administering medication, if applicable.

(7) Conducting or arranging for appropriate laboratory and toxicology testing.

(8) Navigational services for individuals transitioning to the community when available include:

(a) prescription and medication assistance;

(b) arranging for temporary or permanent housing;

(c) family and natural support group planning;

(d) outpatient behavioral health referrals and appointments; and

(e) other services determined through the assessment process.

(9) Assistance in accessing transportation services for recipients who lack safe transportation.

F. Non-covered services: Services furnished by a CTC are subject to the limitations and coverage restrictions that exist for other MAD covered services. See 8.310.2 and 8.321.2 NMAC for general non-covered services. Specific to crisis triage services, the following apply:

(1) Acute medical alcohol detoxification that requires hospitalization as diagnosed by the agency physician or certified nurse practitioner.

(2) Medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR.

G. Prior authorization and utilization review: All MAD services are subject to utilization review (UR) for medical necessity and program compliance. The provider agency must contact HCA or its authorized agents to request UR instructions. It is the provider agency's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials.

(1) Prior authorization: Crisis triage services do not require prior authorization and are provided as approved by the CTC provider agency. Other procedures or services may require prior authorization from MAD or its designee when such services require prior authorization for other MAD eligible recipients, such as inpatient admission. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment has been made. It is the provider agency's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when prior authorization is necessary.

(2) Timing of UR: A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agency agrees to cooperate fully with MAD or its designee in their performance of any review and agree to comply with all review requirements.

H. Reimbursement: Crisis triage center services are reimbursed through an agency specific cost based bundled rate relative to type of services rendered. Billing details are provided in the BH policy and billing manual.

[8.321.2.21 NMAC - Rp, 8.321.2.20 NMAC, 12/10/2024]

8.321.2.22 DAY TREATMENT: MAD pays for services provided by a day treatment provider as part of the EPSDT program for eligible recipients under 21 years of age (42 CFR section 441.57). The need for day treatment services (DTS) must be identified through an EPSDT tot to teen health check or other diagnostic evaluation. Day treatment services include eligible recipient and parent education, skill and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the eligible recipient's school or other child serving agencies is included. The goals of the service must be clearly documented utilizing a clinical model for service delivery and support.

A. Eligible providers: An agency must be certified by CYFD to provide day treatment services per 7.20.11 NMAC in addition to meeting the general provider enrollment requirements in Subsections A and B of 8.321.2.9 NMAC.

B. Coverage criteria:

(1) Day treatment services must be provided in a school setting or other community setting; however, there must be a distinct separation between these services in staffing, program description and physical space from other behavioral health services offered.

(2) A family who is unable to attend the regularly scheduled sessions at the day treatment facility due to transportation difficulties or other reasons may receive individual family sessions scheduled in the family's home by the day treatment agency.

(3) Services must be based upon the eligible recipient's individualized treatment plan goals and should include interventions with a significant member of the family which are designed to enhance the eligible recipients' adaptive functioning in their home and community.

(4) The certified DTS provider delivers adequate care and continuous supervision of the client at all times during the course of the client's DTS program participation.

(5) 24-hour availability of appropriate staff or implementation of crisis plan (which

may include referral) to respond to the eligible recipient's crisis situation.

(6) Only those activities of daily living and basic life skills that are assessed as a clinical problem should be addressed in the treatment plans and deemed appropriate to be included in the eligible recipient's individualized program.

(7) Day treatment services are provided at a minimum of four hours of structured programming per day, two to five days per week based on acuity and clinical needs of the eligible recipient and their family as identified in the treatment plan.

C. Identified population: MAD covers day treatment services for an eligible recipient under age 21 who:

(1) is diagnosed with an emotional, behavioral, and neurobiological or SUD;

(2) may be at high risk of out-of-home placement;

(3) requires structured therapeutic services in order to attain or maintain functioning in major life domains of home, work or school; and

(4) through an assessment process, has been determined to meet the criteria established by MAD or its designee for admission to day treatment services.

D. Covered services:

(1) Day treatment services are non-residential specialized services and training provided during or after school, weekends or when school is not in session. Services include parent and eligible recipient education, and skills and socialization training that focus on the amelioration of functional and behavioral deficits. Intensive coordination and linkage with the eligible recipient's school or other child serving agencies are included. Other behavioral health services (e.g. outpatient counseling, ABA) may be provided in addition to the day treatment services when the goals of the service are clearly documented, utilizing a clinical model for service delivery and support.

(2) The goal of day treatment is to maintain the eligible recipient in their home or community environment.

(3) The service is designed to complement and coordinate with the eligible recipient's educational system.

(4) Services must be identified in the treatment plan, including crisis planning, which is formulated on an ongoing basis by the treatment team. The treatment plan guides and records for each client: individualized therapeutic goals and objectives; individualized therapeutic services provided; and individualized discharge and aftercare plans. Treatment plan requirements are detailed in the BH policy and billing manual.

(5) The following services must be furnished by a day treatment service agency to receive reimbursement from MAD:

(a) the assessment and diagnosis of the social, emotional, physical and psychological needs of the eligible recipient and their family for treatment planning ensuring that evaluations already performed are not unnecessarily repeated;

(b) development of individualized treatment and discharge plans and ongoing reevaluation of these plans;

(c) regularly scheduled individual, family, multifamily, group or specialized group sessions focusing on the attainment of skills, such as managing anger, communicating and problem-solving, impulse control, coping and mood management, chemical dependency and relapse prevention, as defined in the DTS treatment plan;

(d) family training and family outreach to assist the eligible recipient in gaining functional and behavioral skills;

(e) supervision of self-administered medication, as clinically indicated;

(f) therapeutic recreational activities that are supportive of the clinical objectives and identified in each eligible recipient's individualized treatment plan;

(g) 24-hour availability of appropriate staff or implementation of crisis plan, which may include referral, to respond to the eligible recipient's crisis situations;

(h) advance schedules are posted for structured and supervised activities which include individual, group and family therapy, and other planned activities appropriate to the age, behavioral and emotional needs of the client pursuant to the treatment plan.

E. Non-covered services: Day treatment services are subject to the limitations and coverage restrictions which exist for other MAD covered services. See subsection G of 8.321.2.9 NMAC for non-covered MAD behavioral health services or activities. MAD does not cover the following specific services billed in conjunction with day treatment services:

(1) educational programs;

(2) pre-vocational training;

(3) vocational training which is related to specific employment opportunities, work skills or work settings;

(4) any service not identified in the treatment plan;

(5) recreation activities not related to the treatment plan;

(6) leisure time activities such as watching television, movies or playing computer or video games;

(7) transportation reimbursement for the therapist who delivers services in the family's home; or

(8) a partial hospitalization program and residential programs cannot be offered at the same time as day treatment services.

F. Prior authorization: See Subsection J of 8.321.2.9 NMAC for general behavioral health services prior authorization requirements. This service does not require prior authorization.

G. Reimbursement:

(1) All services described in Subsection D of 8.321.2.22 NMAC are covered in the bundled day treatment rate;

(2) Day treatment providers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements, see 8.302.2 NMAC. Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.22 NMAC - Rp, 8.321.2.21 NMAC, 12/10/2024]

8.321.2.23 FAMILY SUPPORT SERVICES (FSS) (MCO reimbursed only): Family support services are community-based, face-to-face interactions with children, youth or adults and their family, available to managed care members only. Family support services enhance the member family's strengths, capacities, and resources to promote the member's ability to reach the recovery and resiliency behavioral health goals they consider most important. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers:

(1) Family support service providers and staff shall meet standards established by the state of NM and documented in the BH policy and billing manual.

(2) Family support service staff and supervision by licensed behavioral health practitioners must be in accordance with their respective licensing board regulations or credentialing standards for peer support workers or family peer support workers.

(3) Minimum staff qualifications for peer support workers or family peer support workers includes maintenance of credentials as a peer support worker or family peer support worker in NM.

(4) Minimum staff qualifications for the clinical supervisor:

(a) must be a licensed RLD board approved clinical supervisor (i.e., psychiatrist, psychologist, LISW, LPCC, LMFT, or psychiatrically certified nurse practitioner) practicing under the scope of their NM licensure;

(b) have four years' relevant experience in the delivery of case management or comprehensive community support services or family support services with the target population;

(c) have one year demonstrated supervisory experience; and

(d) have completed both basic and supervisory training regarding family support services.

B. Identified population:

(1) Members with parents, family members, legal guardians, and other primary caregivers who are living with or closely linked to the member and engaged in the plan of care for the member.

(2) Members are young persons diagnosed with a severe emotional disturbance or adults diagnosed with serious mental illness as defined by the state of NM.

C. Covered services:

(1) Minimum required family support services activities:

(a) review of the existing social history and other relevant information with the member and family;

(b) review of the existing treatment plans;

(c) identification of the member and family functional strengths and any barriers to recovery;

(d) participation in treatment planning and delivery with the member and family; and

(e) adherence to the applicable code of ethics.

(2) The specific services provided are tailored to the individual needs of the member and family according to the individual's treatment or treatment plan and include but are not limited to support needed to:

(a) prevent members from being placed into more restrictive setting; or

(b) quickly reintegrate the member to their home and local community; or

(c) direct the member and family towards recovery, resiliency, restoration, enhancement, and maintenance of the member's functioning; or

(d) increase the family's ability to effectively interact with the member.

(3) Family support services focus on psychoeducation, problem solving, and skills building for the family to support the member and may involve support activities such as:

(a) working with teams engaged with the member;

(b) engaging in treatment planning and service delivery for the member;

(c) identifying family strengths and resiliencies in order to effectively articulate those strengths and prioritize their needs;

(d) navigating the community-based systems and services that impact the member's life;

(e) identifying natural and community supports;

(f) assisting the member and family to understand, adjust to, and manage behavioral health crises and other challenges;

(g) facilitating an understanding of the options for treatment of behavioral health issues;

(h) facilitating an understanding of the principles and practices of recovery and resiliency; and

(i) facilitating effective access and use of the behavioral health service system to achieve recovery and resiliency.

(4) Documentation requirements:

(a) notes related to all family support service interventions to include how and to what extent the activity promoted family support in relationship to the member's recovery and resilience goals and outcomes;

(b) any supporting collateral documentation.

D. Non-covered services: This service may be billed only during the transition phases from these services:

(a) accredited residential treatment center (ARTC);

(b) adult accredited residential treatment center (AARTC);

(c) residential treatment center services;

(d) group home services;

(e) inpatient hospitalization;

(f) partial hospitalization;

(g) treatment foster care; or

(h) crisis triage centers.

[8.321.2.23 NMAC - Rp, 8.321.2.22 NMAC, 12/10/2024]

8.321.2.24 INPATIENT PSYCHIATRIC CARE IN FREESTANDING PSYCHIATRIC HOSPITALS AND PSYCHIATRIC UNITS OF ACUTE CARE HOSPITALS: To assist the eligible recipient in receiving necessary mental health services, MAD pays for inpatient psychiatric care furnished in freestanding psychiatric hospitals as part of the EPSDT program (42 CFR 441.57). A freestanding psychiatric hospital (an inpatient facility that is not a unit in a general acute care hospital), with more than 16 beds is an institution for mental disease (IMD) subject to the federal medicaid IMD exclusion that prohibits medicaid payment for inpatient stays for eligible recipients aged 22 through 64 years. Coverage of stays in a freestanding psychiatric hospital that is considered an IMD are covered only for eligible recipients up to age 21 and over age 64. A managed care organization making payment to an IMD as an in lieu of service may pay for stays that do not exceed 15 days. For stays in an IMD that include a SUD refer to 8.321.2.25 NMAC. For freestanding psychiatric hospitals, if the eligible recipient who is receiving inpatient services reaches the age of 21 years, services may continue until one of the following conditions is reached: until the date the eligible recipient no longer requires the services, or until the date the eligible recipient reaches the age of 22 years, whichever occurs first. The need for inpatient psychiatric care in a freestanding psychiatric hospital must be identified in the eligible recipient's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral. Inpatient stays for eligible recipients in an inpatient psychiatric unit of a general acute care hospital are also covered. As these institutions are not considered to be IMDs, there are no age exclusions for their services.

A. Eligible providers: A MAD eligible provider must be licensed and certified by the NM DOH (or the comparable agency if in another state), comply with 42 CFR 456.201 through 456.245; and be accredited by at least one of the following:

(1) the joint commission (JC);

(2) the council on accreditation of services for families and children (COA);

(3) the commission on accreditation of rehabilitation facilities (CARF); or

(4) another accrediting organization recognized by MAD as having comparable standards; and

(5) be an enrolled MAD provider before it furnishes services, see 42 CFR sections 456.201 through 456.245.

B. Covered services: MAD covers inpatient psychiatric hospital services which are medically necessary for the diagnosis or treatment of mental illness as required by the condition of the eligible recipient.

(1) These services must be furnished by eligible providers within the scope and practice of their profession (see 8.321.2.9 NMAC) and in accordance with federal regulations; see (42 CFR 441.156);

(2) Services must be furnished under the direction of a physician;

(3) In the case of an eligible recipient under 21 years of age these services:

(a) must be furnished under the direction of a board prepared, board eligible, board-certified psychiatrist or a licensed psychologist working in collaboration with a similarly qualified psychiatrist; and

(b) the psychiatrist must conduct an evaluation of the eligible recipient, in person within 24 hours of admission.

(4) In the case of an eligible recipient under 12 years of age, the psychiatrist must be board prepared, board eligible, or board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for an eligible recipient under age 12 and an eligible recipient under 21 years of age can be waived when all of the following conditions are met:

(a) the need for admission is urgent or emergent and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes;

(b) at the time of admission, a psychiatrist who is board prepared, board eligible, or board certified in child

or adolescent psychiatry, is not accessible in the community in which the facility is located;

(c) there is another facility which has a psychiatrist who is board prepared, board eligible, board certified in child or adolescent psychiatry, but the facility, is not available or is inaccessible to the community in which the facility is located; and

(d) the admission is for stabilization only and a transfer arrangement to the care of a psychiatrist who is board prepared, board eligible, board certified in child or adolescent psychiatry, is made as soon as possible with the understanding that if the eligible recipient needs transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer in accordance with professional standards.

(5) A freestanding hospital must provide the following components to an eligible recipient to receive reimbursement:

(a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(b) a treatment plan and all supporting documentation must be available for review in the eligible recipient's file;

(c) regularly scheduled structured behavioral health therapy sessions for the eligible recipient, group, family, or a multifamily group based on individualized needs, as specified in the eligible recipient's treatment plan;

(d) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school, attendance and money management;

(e) assistance to an eligible recipient in their self administration of medication in compliance with state regulations, policies and procedures;

(f) appropriate staff available on a 24-hour basis to respond to crisis situations; determine the severity of the situation; stabilize the eligible recipient by providing support; make referrals, as necessary; and provide follow-up;

(g) a consultation with other professionals or allied caregivers regarding a specific eligible recipient;

(h) non-medical transportation services needed to accomplish treatment objectives;

(i) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of the eligible recipient; and

(j) plans for discharge must begin upon admittance to the facility and be included in the eligible recipient's treatment plan. If the eligible recipient will receive services in the community or in the custody of CYFD, the discharge must be coordinated with those individuals or agencies responsible for post-hospital placement and services. The discharge plan must consider related community services to ensure continuity of care with the eligible recipient, their family, and school and community.

(6) MAD covers "awaiting placement days" when the MAD UR contractor determines that an eligible recipient under 21 years of age no longer meets this acute care criteria and determines that the eligible recipient requires a residential placement which cannot be immediately located. Those days during which the eligible recipient is awaiting placement to the step-down placement are termed awaiting placement days. Payment to the hospital for awaiting placement days is made at the average payment for accredited residential treatment centers plus five percent. A separate claim form must be submitted for awaiting placement days.

(7) A treatment plan must be developed by a team of professionals in consultation with an eligible recipient, their parent, legal guardian, or others in whose care the eligible recipient will be released after discharge. The plan must be developed within 72 hours of admission of the eligible recipient's admission to freestanding psychiatric hospitals. The interdisciplinary team must review the treatment plan at least every five calendar days. See the BH policy and billing manual for a description of the treatment team and plan.

C. Non-covered services: Services furnished in a freestanding psychiatric hospital are subject to the limitations and coverage restrictions which exist for other MAD covered services; see Subsection G of 8.321.2.9 NMAC for MAD general non-covered services. MAD does not cover the following specific services for an eligible recipient in a freestanding psychiatric hospital in the following situations:

(1) conditions defined only by Z codes in the current version of the international classification of diseases (ICD) or the current version of DSM;

(2) services in freestanding psychiatric hospital for an eligible recipient 22 years of age through 64, except as allowed in 8.321.2 NMAC;

(3) services furnished after the determination by MAD or its designee has been made that the eligible recipient no longer needs hospital care;

(4) formal educational or vocational services, other than those covered in Subsection B of 8.321.2.9 NMAC, related to traditional academic subjects or vocational training; MAD only covers non-formal education services if they are part of an active treatment plan for an eligible recipient under the age of 21 receiving inpatient psychiatric services; see 42 CFR Section 441.13(b); or

(5) drugs classified as "ineffective" by the food and drug administration (FDA) drug evaluation.

D. Prior authorization and utilization

review: All MAD services are subject to utilization review for medical necessity, inspection of care, and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made; see 8.310.2 and 8.310.3 NMAC.

(1) All inpatient services for an eligible recipient under 21 years of age in a freestanding psychiatric hospital require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

(2) Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that an individual is eligible for MAD services at the time services are furnished and through their inpatient stay and determine if the eligible recipient has other health insurance.

(3) A provider who disagrees with prior authorization request denials or other review decisions can request a re-review and a reconsideration; see 8.350.2 NMAC.

E. Reimbursement: A freestanding psychiatric hospital service provider must submit claims for reimbursement on the UB-04 claim form or its successor; see 8.302.2 NMAC. Once enrolled, providers receive instructions on how to access documentation, billing, and claims processing information.

(1) Reimbursement rates for NM freestanding psychiatric hospital are based on the tax equity and fiscal responsibility act (TEFRA) provisions and principles of reimbursement; see 8.311.3 NMAC. Covered inpatient services provided in a freestanding psychiatric hospital will be reimbursed at an interim rate established by HCA to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles.

(2) If a provider is not cost settled, the reimbursement rate will be at the provider's cost-to-charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost-to-charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity, and duration.

(3) Reimbursement rates for services furnished by a psychiatrist and licensed Ph.D. psychologist in a freestanding psychiatric hospital are contained in 8.311.3 NMAC. Services furnished by a psychiatrist and psychologist in a freestanding psychiatric hospital cannot be included as inpatient psychiatric hospital charges.

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

(5) The provider agrees to be paid by a MCO at any amount mutually-agreed upon between the provider and MCO when the provider enters into contracts with MCO contracting with HCA for the provision of managed care services to an eligible recipient.

(a) if the provider and the HCA contracted MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated to pay, and the provider shall accept, one hundred percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(b) the "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in the medical assistance programs administered by MAD and excludes disproportionate share hospital and medical education payments.

[8.321.2.24 NMAC - Rp, 8.321.2.23 NMAC, 12/10/2024]

8.321.2.25 INSTITUTION FOR MENTAL DISEASES (IMD) FOR SUBSTANCE USE DISORDER (SUD): IMD is defined as any facility with more than 16 beds that is primarily engaged in the delivery of psychiatric care or treating substance use disorders (SUD) that is not part of a certified general acute care hospital. The federal medicaid IMD exclusion generally prohibits payment to these providers for recipients aged 22 through 64. MAD covers inpatient hospitalization in an IMD for SUD diagnoses only with criteria for medical necessity and based on ASAM admission criteria. The coverage may also include co-occurring behavioral health disorders with the primary SUD. For other approved IMD stays for eligible recipients under age 21 or over age 64, the number of days is determined by medical necessity as the age restriction for IMDs does not apply to ages under 21 or over 65. Also refer to 8.321.2.24 NMAC.

A. Eligible recipients: Adolescents and adults with a mental health or SUD or co-occurring mental health and SUD.

B. Covered services: Withdrawal management (detoxification) and rehabilitation.

C. Prior authorization is required. Utilize the substance abuse and mental health services administration (SAMHSA) admission criteria for medical necessity.

D. Reimbursement: An IMD is reimbursed according to the provisions in Subsection E of 8.321.2.23 NMAC.

[8.321.2.25 NMAC - Rp, 8.321.2.24 NMAC, 12/10/2024]

8.321.2.26 INTENSIVE OUTPATIENT PROGRAM (IOP) FOR SUBSTANCE USE DISORDERS (SUD): MAD pays for time limited IOP services utilizing a multi-faceted approach to treatment for an eligible recipient who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved through the process

described in the BH policy and billing manual and target specific behaviors with individualized behavioral interventions.

A. Eligible providers: Services must be delivered through an agency approved through the application process described in the BH policy and billing manual. Prior to medicaid enrollment the agency must demonstrate that the agency meets all the requirements of IOP program services and supervision. See Subsection A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) IOP services are provided through an integrated interdisciplinary approach including staff expertise in both SUD and mental health treatment. This team may have services rendered by non-independently licensed and non-licensed practitioners within their scope of practice and under the direction of the IOP RLD board approved clinical supervisor. See Subsection E of 8.321.2.9 NMAC for non-independent and non-licensed practitioners and Subsection C of 8.321.2.9 NMAC for independently licensed professionals eligible to conduct IOP clinical supervision.

(2) Each IOP program must have an independently licensed RLD board approved clinical supervisor. Both clinical services and supervision by independently licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) have two or more years of relevant experience with an IOP program or approved exception by submitting a request through the process described in the BH policy and billing manual; and

(b) have expertise in both mental health and substance use disorder treatment.

(3) The IOP agency is required to develop and implement a program outcome evaluation system which may include consumer satisfaction surveys, retention into service rates, drop-out rates, re-admittance or relapse and lapse rates, incarceration or hospitalization data, or readily identifiable information and data specific to the IOP.

(4) The agency must maintain the appropriate state facility licensure and abide by all applicable state and federal regulations if offering medication for opioid use disorder.

(5) The agency must hold an IOP approval letter as described in the BH policy and billing manual and be enrolled by MAD to render IOP services to an eligible recipient. In the application process each IOP must identify if it is a youth program, an adult program, a transitional age program, or multiple programs. Transitional age programs must specify the age range of the target population. As described in the BH policy and billing manual an IOP will receive provisional approval to begin rendering IOP services prior to receiving full approval.

B. Coverage criteria:

(1) An IOP is based on research and evidence-based practice (EBP) models that target specific behaviors with individualized behavioral interventions. All EBP services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. EBPs must be approved through the process described in the BH policy and billing manual. A list of pre-approved EBPs is available through the council, as are the criteria for having another model approved.

(2) Treatment services must address co-occurring substance used and mental health disorders. Care coordination should be available to ensure integrated care for medical conditions either by referral or internally.

C. Covered services:

(1) IOP core services must include:

(a) individual SUD related therapy;

(b) group therapy (group membership may not exceed 15 in number); and

(c) psychoeducation for the eligible recipient and their family or significant other.

(2) Co-occurring mental health and SUD: The IOP agency must accommodate the needs of an eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated interdisciplinary team and through coordinated, concurrent services with behavioral health providers.

(3) Medication management services must accessible either in the IOP agency or by referral to oversee the use of psychotropic medications and medication assisted treatment of SUD.

(4) The amount and intensity of an eligible recipient's IOP intervention is typically three to six months and between 9-19 hours for adults or 6-19 hours for adolescents per week. The amount of weekly services per eligible recipient is directly related to the goals specified in their IOP treatment plan and the IOP EBP in use. Recipients must meet ASAM 2.1 level of care placement criteria and have been diagnosed with a moderate or severe SUD to be eligible to receive SUD IOP services.

(5) Other mental health therapies: Outpatient therapies may be rendered in addition to the IOP therapies of individual and group when the eligible recipient's co-occurring disorder requires treatment services which are outside the scope of the IOP therapeutic services. The eligible recipient's file must document the medical necessity of receiving outpatient therapy services in addition to IOP therapies. Such documentation includes, but is not limited to current assessment, a co-occurring diagnosis, and inclusion in the treatment plan for outpatient therapy services. An IOP agency may:

(a) render these services when it is enrolled as a provider covered under Subsection D of 8.321.2.9 NMAC with practitioners listed in

Subsections C and E of 8.321.2.9 NMAC whose scope of practice specifically allows for mental health therapy services; or

(b) refer the eligible recipient to another provider if the IOP agency does not have such practitioners available; the IOP agency may continue the eligible recipient's IOP services coordinating with the new provider.

D. Identified population:

(1) IOP services are provided to an eligible recipient 11 through 17 years of age diagnosed with a substance use disorder or with co-occurring disorders (mental illness and SUD) and that meet the American society of addiction medicine (ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment; or have been mandated by the local judicial system as an option of least restrictive level of care. Adolescents who turn 18 years old while in an IOP program may remain until appropriate discharge. Services are not covered if the recipient is in detention or incarceration. See eligibility rules 8.200.410.17 NMAC.

(2) IOP services are provided to an eligible recipient of a transitional age program of which the age range has been determined by the agency, and that have been diagnosed with substance use disorder or with co-occurring disorders (mental illness and substance use) or that meet the American society of addiction medicine's (ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment, or have been mandated by the local judicial system as an option of least restrictive level of care.

(3) IOP services are provided to an eligible adult recipient 18 years of age and older diagnosed with substance use disorders or co-occurring disorders (mental illness and substance use) that meet the American society of addiction medicine's (ASAM) patient placement criteria for level 2.1 - intensive outpatient treatment of have been mandated by the local judicial system as an option of least restrictive level of care.

(4) Prior to engaging in an IOP program, the eligible recipient must have a treatment file containing:

(a) a diagnostic evaluation with a diagnosis of a moderate or severe SUD;

(b) an individualized IOP treatment plan that includes IOP and the EBP as the intervention; and

(c) both a crisis and safety plan developed with the recipient. The treatment, crisis, and safety plans must be regularly updated in collaboration with the recipient.

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD covered services see Subsection G of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services. MAD does not cover the following specific services billed in conjunction with IOP services.

(1) acute inpatient;

(2) residential treatment services (i.e., ARTC, RTC, group home, and transitional living services);

(3) partial hospitalization;

(4) outpatient therapies which do not meet Subsection C of 8.321.2.9 NMAC; or

(5) activity therapy.

F. Reimbursement: See Subsection H of 8.321.2.9 NMAC for MAD behavioral health general reimbursement requirements.

(1) For IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor.

(2) Core IOP services are reimbursed through a daily rate. Medication assisted treatment and other mental health therapies are billed and reimbursed separately from the daily rate.

(3) IOP services furnished by an IOP team member are billed by and reimbursed to a MAD IOP agency whether the team member is under contract with or employed by the IOP agency.

(4) IOP services not provided in accordance with the conditions for coverage as specified in 8.321.2 NMAC are not MAD covered services and are subject to recoupment.

[8.321.2.26 NMAC - Rp, 8.321.2.25 NMAC, 12/10/2024]

8.321.2.27 INTENSIVE OUTPATIENT PROGRAM (IOP) FOR MENTAL HEALTH CONDITIONS: MAD pays for IOP services which provide a time limited, multi-faceted approach to treatment for an eligible recipient with a SMI or SED including an eating disorder or borderline personality disorder who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved through the process described in the BH policy and billing manual and target specific behaviors with individualized behavioral interventions.

A. Eligible providers: Services must be delivered through a MAD enrolled agency. IOP agencies must complete the application process as outlined in the BH policy and billing manual. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

(1) IOP services are provided through an integrated interdisciplinary approach by staff with expertise in the mental health condition being addressed. This team may have services rendered by non-independently licensed and non-licensed practitioners under the direction of a RLD board approved clinical supervisor. See Subsection E of 8.321.2.9 NMAC for non-independent and non-licensed practitioners and Subsection C of 8.321.2.9 NMAC for independently licensed professionals eligible to conduct IOP clinical supervision.

(2) Each IOP program must have an independently licensed board approved clinical supervisor. Both clinical services and supervision by licensed practitioners must be conducted in accordance with respective licensing board regulations. An IOP clinical supervisor must meet all the following requirements:

(a) have two years or more relevant experience; and

(b) have one or more years demonstrated clinical supervisory experience.

(3) The IOP agency is required to develop and implement a program outcome evaluation system.

(4) The agency must maintain the appropriate state facility licensure if offering medication treatment.

(5) The agency must hold an IOP approval letter and be enrolled by MAD to render IOP services to an eligible recipient. In the application process each IOP must identify if it is a youth program, an adult program, a transitional age program, or multiple programs. Transitional age programs must specify the age range of the target population. As described in the BH policy and billing manual an IOP will receive provisional approval to begin rendering IOP services prior to receiving full approval.

B. Coverage criteria:

(1) An IOP is based on research and applies EBP models that target specific behaviors with individualized behavioral interventions. All EBP services must be culturally sensitive and incorporate recovery and resiliency values into all service interventions. EBPs must be approved through the process described in the BH policy and billing manual. A list of pre-approved EBPs is available through the council, as are the criteria for having another model approved.

(2) Treatment services must address a primary SMI or SED and co-occurring SUD when indicated. Care coordination should be available to ensure integrated care for medical conditions either by referral or internally.

C. Covered services:

(1) IOP core services must include:

(a) individual therapy;

(b) group therapy (group membership may not exceed 15 in number; and

(c) psychoeducation for the eligible recipient and their family or significant other.

(2) Co-occurring mental health and SUD. The IOP agency must accommodate the needs of an eligible recipient with co-occurring substance use and mental health disorders. Treatment services are provided through an integrated interdisciplinary team and through coordinated, concurrent services with behavioral health providers.

(3) Medication management services must be accessible either in the IOP agency or by referral to oversee the use of psychotropic medications and medication assisted treatment of SUD.

(4) The duration and intensity of an eligible recipient's IOP intervention is typically three to six months and between 9-19 hours for adults or 6-19 hours for adolescents per week. The amount of weekly services per eligible recipient is directly related to the goals specified in their IOP treatment plan and the IOP EBP in use. Recipients must meet SMI/SED criteria and have a diagnosis to be eligible to receive MH IOP services.

(5) Other mental health therapies: outpatient therapies may be rendered in addition to the IP therapies of individual and group when the eligible recipient's co-occurring disorder requires treatment services which are outside the scope of IOP therapeutic services. The eligible recipient's file must document the medical necessity of receiving outpatient therapy services. Such documentation includes, but is not limited to current assessment, a co-occurring diagnosis, and the inclusion of a service plan for outpatient therapy services. An IOP agency may:

(a) render these services when it is enrolled as a provider covered under Subsection D of 8.321.2.9 NMAC with practitioners listed in Subsection C and E of 8.321.2.9 NMAC whose scope of practice specifically allows for mental health therapy services; or

(b) refer the eligible recipient to another provider if the IOP agency does not have such practitioners available. The IOP agency must coordinate the recipients transfer to the new provider.

D. Identified population:

(1) IOP services are provided to an eligible recipient, 11 through 17 years of age diagnosed with a SED or have been mandated by the local judicial system as an option of least restrictive level of care. Adolescents who turn 18 years old while in an IOP program may remain until appropriate discharge.

(2) IOP services are provided to an eligible recipient of a transitional age program of which the age range has been determined by the agency, and is diagnosed with substance use disorder or with co-occurring disorders (mental illness and substance use) or that meet the ASAM patient placement criteria for level 2.1 - intensive outpatient treatment, or have been mandated by the local judicial system as an option or least restrictive level of care.

(3) IOP services are provided to an eligible adult recipient 18 years of age and older diagnosed with a SMI; or have been mandated by local judicial system as an option of least restrictive level of care.

(4) Prior to engaging in an IOP program, the eligible recipient must have a treatment file containing:

(a) a diagnostic evaluation with a diagnosis of serious mental illness or severe emotional disturbance; or diagnosis for which the IOP is approved;

(b) an individualized IOP treatment plan that includes IOP and the EBP as the intervention; and

(c) both a crisis and safety plan developed with the recipient.

The treatment, crisis, and safety plans must be regularly updated in collaboration with the recipient.

E. Non-covered services: IOP services are subject to the limitations and coverage restrictions which exist for other MAD covered services see Subsection G. of 8.321.2.9 NMAC for general non-covered MAD behavioral health services and 8.310.2 NMAC for MAD general non-covered services. MAD does not cover the following specific services billed in conjunction with IOP services:

(1) acute inpatient;

(2) residential treatment services (i.e., ARTC, RTC, group home, transitional living services);

(3) partial hospitalization;

(4) outpatient therapies which do not meet Subsection C of 8.321.2.9 NMAC; or

(5) activity therapy.

F. Reimbursement: See Subsection H of 8.321.2.9 NMAC for MAD behavioral health general reimbursement.

(1) For IOP services, the agency must submit claims for reimbursement on the CMS-1500 claim form or its successor.

(2) Core IOP services are reimbursed through a daily rate. Medications and other mental health therapies are billed and reimbursed separately from the daily rate.

(3) IOP services furnished by an IOP team member are billed by and reimbursed to a MAD IOP agency whether the team member is under contract with or employed by the IOP agency.

(4) IOP services not provided in accordance with the conditions for coverage as specified in the rule are not a MAD covered service and are subject to recoupment.

[8.321.2.27 NMAC - Rp, 8.321.2.26 NMAC, 12/10/2024]

8.321.2.28 MEDICATION ASSISTED TREATMENT (MAT): BUPRENORPHINE TREATMENT FOR OPIOID USE DISORDER: MAD pays for coverage for medication assisted treatment (MAT) for opioid use disorder to an eligible recipient as defined in the Drug Addiction Treatment Act of 2000 (DATA 2000), the Comprehensive Addiction and Recovery Act of 2016 (CARA), and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act). Services include, but are not limited to, medication for opioid use disorder (excluding methadone) to an eligible recipient for medically managed withdrawal form opioids or medication for opioid use disorder. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Any clinic, office, or hospital staffed by required practitioners.

(2) Practitioners for diagnosing, assessing, and prescribing include:

(a) a physician or DO licensed in the state of NM and has completed drug enforcement agency (DEA) approved training and has the federal waiver to prescribe buprenorphine;

(b) an advanced practice registered nurse that has completed DEA approved training; or

(c) a physician assistant licensed in the state of NM and has the federal DATA 2000 waiver to prescribe buprenorphine.

(3) Practitioners for administration and education:

(a) a registered nurse licensed in the state of NM; or

(b) a physician assistant licensed in the state of NM.

(4) Practitioners for counseling and education may include behavioral health practitioners licensed for counseling or therapy.

(5) Practitioners for skills and education include certified peer support workers or certified family peer support workers to provide skill-building, recovery, and resiliency support.

B. Coverage criteria:

(1) an assessment and diagnosis, which may be conducted either in person or via telehealth, by the prescribing practitioner to determine whether the recipient has an opioid use diagnosis and their readiness for change must be conducted prior to starting treatment;

(2) an assessment for concurrent medical or behavioral health illnesses;

(3) an assessment for co-occurring substance use disorders;

(4) providing psychoeducation related to all available treatment options, prior to starting treatment; and

(5) a treatment plan that prescribes either in house counseling or therapy, or referral to outside services, as indicated.

C. Eligible recipients: Individuals with an opioid use disorder diagnosis defined by DSM 5 or ICD 10.

D. Covered services:

(1) history and physical;

(2) comprehensive assessment and treatment plan;

(3) induction phase of opioid treatment;

(4) administration of medication and concurrent education;

(5) subsequent evaluation and management visits;

(6) development and maintenance of medical record log of opioid replacement medication prescriptions;

(7) development and maintenance of required records regarding inventory, storage and destruction of controlled medications if dispensing from office;

(8) initiation and tracking of controlled substance agreements with eligible recipients;

(9) regular monitoring and documentation of NM prescription monitoring program results;

(10) urine drug screens;

(11) recovery services (MCO members only);

(12) family support services (MCO members only).

E. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See the BH policy and billing manual for reimbursement specific to MAT. [8.321.2.28 NMAC - Rp, 8.321.2.27 NMAC, 12/10/2024]

8.321.2.29 MULTI-SYSTEMIC THERAPY (MST) and MST PROBLEM SEXUAL BEHAVIOR (MST-PSB): To help an eligible recipient 10 up to 18 years of age receive behavioral health services to either remain in or re-enter their home and community, MAD pays for MST and MST-PSB services as part of EPSDT program (42 CFR 441.57). MAD covers medically necessary MST services required by the condition of the eligible recipient. MST provides intensive home, family and community-based treatment for an eligible recipient 10 to 18 years of age who is at risk of out-of-home placement or is returning home from an out-of-home placement. The need for MST services must be identified in the eligible recipient's tot to teen health check screen or another diagnostic evaluation. MST is an intensive family and community, evidence-based treatment for youth who are at risk of out-of-home placement or are returning home from out-of-home placement. MST addresses the multiple causes of serious antisocial behavior across key systems within which youth are embedded. MST-PSB focuses on aspects of a youth's ecology that are functionally related to the problem sexual behavior. Unless otherwise described below the acronym MST may be interpreted to include both MST and MST-PSB. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient. The acronym MST used throughout this section includes both MST and MST-PSB unless otherwise specified.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing MST services, an agency must hold a copy of MST Inc licensure, or any of its approved subsidiaries and meet the state licensure and provider enrollment requirements for each MST team. Additionally, the agency must complete the application process as described in the behavioral health billing and policy manual. All clinical staff are required to complete a prescribed five-day MST introductory training and subsequent quarterly trainings. Any staff person providing MST-PSB must have completed the MST-PSB specific training and be on a specially trained team with national certification from MST Services, LLC for MST-PSB.

(1) The MST program includes an assigned MST team for each eligible recipient. The MST team must include at minimum:

(a) master's level independently licensed behavioral health professional clinical supervision; see Subsection H of 8.321.2.9 NMAC;

(b) licensed master's and bachelor's level behavioral health staff able to provide 24-hour coverage, seven days a week; see Subsection E of 8.321.2.9 NMAC;

(c) a licensed master's level behavioral health practitioner that is required to perform all MST interventions; a bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of their RLD practice board licensure or practice (see Subsection E of 8.321.2.9 NMAC);

(d) bachelor's level staff that has a degree in social work, counseling, psychology, or a related human services field and must have at least three years' experience working with the identified population of children, adolescents, and their families. Bachelor's level staff may provide the non-clinical components of treatment including treatment planning, skill-building, and family psychoeducation but not family therapy; and

(e) staffing for MST services is comprised of no more than one-third bachelor's level staff and, at minimum, two-thirds licensed master's level staff unless an exception is granted by MST Services, LLC.

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner (see Subsection C of 8.321.2.9 NMAC) who is MST trained; this supervision, following the MST supervisory protocol, is provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis; and

(b) one hour of local group supervision per week and one hour of telephone consultation per week with the MST systems supervisor, provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis.

(3) All clinical staff is required to participate in and complete a prescribed five-day MST introductory training and subsequent quarterly trainings.

B. Identified population:

(1) MST is provided to an eligible recipient 10 to 18 years of age who meets the criteria of SED, involved in or at serious risk of involvement with the juvenile justice system; has antisocial, aggressive, violent, and substance-using behaviors; is at risk for an out-of-home placement; or is returning from an out-of-home placement where the above behaviors were the focus of their treatment and their family's involvement. MST for youth with problem sexual behaviors (MST-PSB) is a clinician adaptation of MST that has been specifically designed and developed to treat youth for problematic sexual behavior.

(2) A co-occurring diagnosis of SUD shall not exclude an eligible recipient from the program.

C. Covered services and service limitations: MST is a culturally sensitive service, rendered by a MST team, to provide intensive home, family, and community-based treatment for the family of an eligible recipient who is at risk of an out-of-home placement or is returning home from an out-of-home placement. MST services are provided in the community. Specialized therapeutic and rehabilitative interventions are used to address specific areas of need, such as substance use, delinquency, and violent behavior. MST service components include treatment planning; restoration of social skills which is available 24-hours a day, seven days a week; and family therapy and psychoeducation.

(1) The following services must be furnished as part of the MST service to be eligible for reimbursement:

(a) an initial assessment to identify the focus of the MST intervention;

(b) therapeutic interventions with the eligible recipient and their family;

(c) case management; and

(d) crisis stabilization.

(2) MST services are conducted by practitioners using the MST team approach. The MST team must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. MST services:

(a) promote the recipient's family's capacity to monitor and manage their behavior;

(b) involve the eligible recipient's family and other systems, such as the school, probation officers, extended families and community connections;

(c) provide access to a variety of interventions 24-hours a day, seven days a week, by staff that maintain contact and intervene as one organizational unit;

(d) include structured face-to-face therapeutic interventions to provide support and guidance in all areas of the recipient's functional domains, such as adaptive, communication, psychosocial, problem solving, and behavior management; and

(e) services provided to family members or other supports must be for the direct benefit of the medicaid recipient.

(3) The duration of MST intervention is typically three to six months. Weekly interventions may range from three to 20 hours a week; less as an eligible recipient nears discharge.

D. Non-covered services: MST services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

E. Reimbursement: MST agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the MST agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.29 NMAC - Rp, 8.321.2.28 NMAC, 12/10/2024]

8.321.2.30 NON-ACCREDITED RESIDENTIAL TREATMENT CENTERS (RTC) AND GROUP HOMES: MAD pays for medically necessary services for an eligible recipient under 21 years of age which are designed to develop skills necessary for successful reintegration into their family or transition into their community. A determination must be made that the eligible recipient needs the level of care (LOC) for services furnished in a RTC or group home. This determination must have considered all environments which are least restrictive, meaning a supervised community placement, preferably a placement with the juvenile's parent, guardian or relative. A facility or conditions of treatment that is a residential or institutional placement should only be utilized as a last resort based on the best interest of the juvenile or for reasons of public safety. Residential services must be rehabilitative and provide access to necessary treatment services in a therapeutic environment. MAD pays for services furnished in a RTC or group home as part of EPSDT program (42 CFR 441.57). The need for RTC and group home services must be identified in the eligible recipient's tot to teen health check screen or other diagnostic evaluation furnished through a health check referral.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing RTC or group home services to an eligible recipient, an agency must meet the following requirements:

(1) a RTC must be certified by the children, youth and families department (CYFD) see 7.20.11 NMAC;

(2) a group home must be certified per 7.20.11 NMAC and licensed per 7.20.12 NMAC by CYFD;

(3) if the RTC is operated by IHS or by a federally recognized tribal government, the facility must meet CYFD RTC licensing and certification requirements but is not required to be licensed or certified by CYFD. In lieu of receiving a license and certification, CYFD provides MAD copies of its facility findings and recommendations. MAD will work with the facility to address recommendations. The BH policy and billing manual provides guidance for addressing the facility findings and recommendations.

(4) RTCs and group homes must allow individuals the opportunity to notify their family that they have been admitted to the facility and shall not admit an individual for residential treatment without obtaining or providing evidence that the facility has attempted to obtain contact information for a family member of the patient.

B. Covered services: Residential treatment services are provided through a treatment team approach and the roles, responsibilities and leadership of the team are clearly defined. MAD covers accommodation and residential treatment services which are medically necessary for the diagnosis and treatment of an eligible recipient's condition. A RTC or group home must provide an interdisciplinary psychotherapeutic treatment program on a 24-hour basis to the eligible recipient through the provision of a 24-hour therapeutic group living environment to meet their developmental, psychological, social, and emotional needs. The following are covered services:

(1) performance of necessary evaluations, assessments and psychological testing of the eligible recipient for the development of their treatment plan for each service, while ensuring that assessments already performed are not repeated;

(2) provide regularly scheduled counseling and therapy sessions in an individual, family or group setting following the eligible recipient's individualized treatment plan;

(3) facilitation of age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management to the eligible recipient;

(4) assistance to the eligible recipient in their self-administration of medication in compliance with state statute, regulation and rules;

(5) provision of appropriate on-site staff based upon the acuity of recipient needs on a 24-hour basis to ensure adequate supervision of the recipients, and response in a proactive and timely manner. Response to crisis situations, determining the severity of the situation, stabilizing the eligible recipient by providing individualized treatment plan/safety plan interventions and support, and making referrals for emergency services or to other non-agency services, as necessary, and providing follow-up;

(6) development of an interdisciplinary treatment plan; see the BH policy and billing manual;

(7) non-medical transportation services needed to accomplish the treatment objective;

(8) therapeutic services to meet the physical, social, cultural, recreational, health maintenance and rehabilitation needs of the eligible recipient;

(9) for planning of discharge and aftercare services to facilitate timely and appropriate post discharge care regular assessments are conducted. These assessments support discharge planning and effect successful discharge with clinically appropriate after care services. This discharge planning begins when the recipient is admitted to residential treatment services and is updated and documented in the recipient record at every treatment plan review, or more frequently as needed; and

(10) the RTC and group homes provide services, care, and supervision at all times, including:

(a) the provision of, or access to, medical services on a 24-hour basis; and

(b) maintenance of a staff-to-recipient ratio appropriate to the level of care and needs of the recipients.

C. Non-covered services: RTC and group home services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general MAD behavioral health non-covered services or activities. MAD does not cover the following specific services billed in conjunction with RTC and group home services to an eligible recipient:

(1) comprehensive community support services (CCSS) except by a CCSS agency when discharge planning with the eligible recipient from the RTC or group home facility;

(2) services not considered medically necessary for the condition of the eligible recipient, as determined by MAD or its UR contractor;

(3) room and board;

(4) services for which prior approval was not obtained; or

(5) services furnished after a MAD or UR contractor determination that the recipient no longer meets the LOC for RTC or group home care.

D. Treatment plan: A treatment plan is required, see Subsection K of 8.321.2.9 NMAC and the BH policy and billing manual.

E. Prior authorization: Before a RTC or group home service is furnished to an eligible recipient, prior authorization is required from MAD or its UR contractor or the respective MCO. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

F. Reimbursement: A RTC or group home agency must submit claims for reimbursement on the UB-04 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. For IHS and a tribal 638 facility and any other "Indian Health Care Provider (IHCP)" defined in 42 Code of Federal Regulations Section 438.14(a), MAD considers RTC services to be outside the IHS all-inclusive rate and RTC is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated

(1) The fee schedule is established after considering cost data submitted by the RTC or group home agency. Cost data is grouped into various cost categories for purposes of analysis and rate setting. These include direct service, direct service supervision, therapy, admission and discharge planning, clinical support, non-personnel operating, administration, and consultation.

(a) The MAD reimbursement covers those services considered routine in the residential setting. Routine services include, but are not limited to counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration.

(b) Services which are not included in the RTC or group home rate include:

(i) direct services furnished by a psychiatrist or licensed Ph.D. psychologist; these services can be billed directly by the provider; see 8.310.3 NMAC; and

(ii) other MAD services that an eligible recipient might require that are not furnished by the facility, such as pharmacy services, primary care visits, laboratory, or radiology services, are billed directly by the applicable providers and are governed by the applicable sections of NMAC rules.

(c) Services which are not covered in the routine rate and are not a MAD covered service include:

(i) room and board; and

(ii) services not related to medical necessity, clinical treatment, and patient care.

(2) A vacancy factor of 24 days annually for each eligible recipient is built into the rate to allow for therapeutic leave and trial community placement. Since the vacancy factor is built into the rate, a RTC and group home agency cannot bill or be reimbursed for days when the eligible recipient is absent from the facility.

[8.321.2.30 NMAC - Rp, 8.321.2.29 NMAC, 12/10/2024]

8.321.2.31 OPIOID TREATMENT PROGRAM (OTP): MAD pays for coverage for medication assisted treatment for opioid use disorder to an eligible recipient through an opioid treatment center as defined in (42 CFR Part 8), certification of opioid treatment programs (OTP). Services include, but are not limited to, the administration of methadone to an individual for medically managed withdrawal from opioids and maintenance treatment. The administration/supervision must be delivered in conjunction with the overall treatment based upon a treatment plan that reflects shared decision making between the patient and health care practitioner or counselor, to include availability of counseling as well as, case review, drug testing, and medication monitoring. Availability of counseling is a required OTP service however access to medication for an enrolled recipient is not contingent upon receipt of counseling services. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Provider requirements:

(a) Accreditation with a substance use and mental health services administration (SAMHSA)/CSAT approved nationally recognized accreditation body, (e.g., commission on accreditation of rehabilitation facilities (CARF), joint commission (JC) or council on accreditation of services for families and children (COA).

(b) Behavioral health services division (BHSD) approval. As a condition of approval to operate an OTP, the OTP must maintain above accreditation. In the event that such accreditation lapses, or approval of an application for accreditation becomes doubtful, or continued accreditation is subject to any formal or alleged finding of need for improvement, the OTP program will notify the BHSD within two business days of such event. The OTP program will furnish the BHSD with all information related to its accreditation status, or the status of its application for accreditation, upon request.

(c) The BHSD shall grant approval or provisional approval to operate pending accreditation, provided that all other requirements of these regulations are met.

(2) Staffing requirements:

(a) Both clinical services and supervision by licensed practitioners must be in accord with their respective licensing board regulations. Provider staff members must be culturally competent.

(b) Programs must be staffed by:

(i) medical director (MD licensed to practice in the state of NM or a DO licensed to practice in the State of NM);

(ii) clinical supervisor (must be one of the following: licensed psychologist,

or licensed independent social worker; or certified nurse practitioner in psychiatric nursing; or licensed professional clinical mental health counselor; or licensed marriage and family therapist;

(iii) licensed behavioral health practitioner; registered nurse; or licensed practical nurse; and

(iv) full time or part time pharmacist.

(c) Programs may also be staffed by:

(i) licensed substance abuse associate (LSAA); and

(ii) certified peer support worker (CPSW).

B. Coverage criteria:

(1) A physician licensed to practice in NM is designated to serve as medical director and to have authority over all medical aspects of opioid treatment.

(2) The OTP shall formally designate a program sponsor who shall agree on behalf of the OTP to adhere to all federal and state requirements and regulations regarding the use of opioid agonist treatment medications in the treatment of opioid use disorder which may be promulgated in the future.

(3) The OTP shall be open for patients every day of the week with an option for closure for federal and state holidays, and Sundays, and be closed only as allowed in advance in writing by CSAT and the state opioid treatment authority. Clinic hours should be conducive to the number of patients served and the comprehensive range of services needed.

(4) Written policies and procedures outlined in the BH policy and billing manual are developed, implemented, compiled, and maintained at the OTP.

(5) OTP programs will not deny a reasonable request for transfer.

(6) The OTP will maintain criteria for determining the amount and frequency of counseling that is provided to a patient.

(7) Referral or transfer of recipients to a suitable alternative treatment program. Because of the risks of relapse following medically managed withdrawal from medication or other opioids, patients must be offered a relapse prevention program that includes, but is not limited to, counseling, naloxone, and medication for opioid use disorder.

(8) Provision of unscheduled treatment or counseling to patients.

(9) Established counselor caseloads based on the intensity and duration of counseling required by each patient. Counseling can be provided in person or via telehealth. Counselor to patient ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.

(10) Preparedness planning: the program has a list of all patients and the patients' dosage requirements available and accessible to program on call staff members.

(11) Patient records: The OTP program shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. The system shall comply with all federal and state requirements relevant to OTPs and to confidentiality of patient records.

(12) Diversion control: a written plan is developed, implemented, and complied with to prevent diversion of opioid treatment medication from its intended purpose to illicit purposes. This plan shall assign specific responsibility to licensed and administrative staff for carrying out the diversion control measures and functions described in the plan. The program shall develop and implement a policy and procedure providing for the reporting of theft or division of medication to the relevant regulatory agencies, and law enforcement authorities.

(13) Prescription monitoring program (PMP): a written plan is developed, implemented, and complied with to ensure that all OTP physicians and other health care providers, as permitted, are registered to use the NM PMP. The PMP should be checked quarterly through the course of each patient's treatment.

(14) HIV/AIDS, hepatitis, and other sexually transmitted infection (STI) testing and education are available to patients either at the provider or through referral, including treatment, peer group or support group and to social services either at the provider or through referral to a community group.

(15) Requirements for health care practitioners who prescribe, distribute or dispense opioid analgesics:

(a) A health care practitioner who prescribes, distributes or dispenses an opioid analgesic for the first time to a patient shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist.

(b) For a patient to whom an opioid analgesic has previously been prescribed, distributed or dispensed by the health care practitioner, the health care practitioner shall advise the patient on the risks of overdose and inform the patient of the availability of an opioid antagonist on the first occasion that the health care practitioner prescribes, distributes or dispenses an opioid analgesic each calendar year.

(c) A health care practitioner who prescribes an opioid analgesic for a patient shall co-prescribe an opioid antagonist if the amount of opioid analgesic being prescribed is at least a five-day supply. The prescription for the opioid antagonist shall be accompanied by written information regarding the temporary effects of the opioid antagonist and techniques for administering the opioid antagonist. That written information shall contain a warning that a person administering the opioid antagonist should call 911

immediately after administering the opioid antagonist.

C. Identified population:

(1) An eligible recipient is treated for opioid dependency only after the agency's medical director or licensed practitioner determines and documents that:

(a) the recipient meets the definition of opioid use disorder using generally accepted medical criteria, such as those contained in the current version of the DSM;

(b) the recipient has received an initial medical examination as required by 7.32.8.19 NMAC which may be conducted either in-person or via telehealth; and

(c) informed consent for treatment must be provided by a parent, guardian, custodian or responsible adult designated by the relevant state authority if the recipient is under the age of 18. Consent may be provided electronically.

(2) OTPs must maintain current policies and procedures that reflect the special needs and priority for treatment of recipients with opioid use disorder who are pregnant. Evidence-based treatment protocols for pregnant patients, such as a split dosing regimen, may be instituted after assessment by an OTP practitioner. Prenatal care and other sex-specific services, including reproductive health services for pregnant and postpartum patients must be provided, and documented, by either the OTP or by referral to an appropriate healthcare practitioner.

D. Covered services:

(1) Withdrawal treatment and medically supervised dose reduction.

(2) A biopsychosocial assessment will be conducted by a licensed behavioral health professional or a LADAC under the supervision of an independently licensed clinician, as defined by the NM RLD within 14 days of admission.

(3) A comprehensive, patient centered, individualized treatment plan, reflecting shared decision making between the patient and the licensed practitioner, shall be conducted within 30 days of admission and be documented in the patient record.

(4) Each OTP will ensure that adequate medical, psychosocial counseling, mental health, vocational, educational, and other services identified in the initial and ongoing treatment plans are fully and reasonably available to patients, either by the program directly, or through formal, documented referral agreements with other providers.

(5) Drug screening: A recipient in comprehensive maintenance treatment receives one random urine drug detection test per month; short-term opioid treatment withdrawal procedure patients receive at least one initial drug use test; long-term opioid treatment withdrawal procedure patients receive an initial and monthly random tests; and other toxicological tests are performed according to written orders from the program medical director or medical practitioner designee. Samples that are sent out for confirmatory testing (by internal or external laboratories) are billed separately by the laboratory.

(6) Initiation of the following mandatory laboratory tests:

(a) a mantoux skin test;

(b) a test for syphilis;

(c) hepatitis screening in accordance with the most current CDC guidelines; and

(d) a laboratory drug detection test for at least opioids, methadone, amphetamines, cocaine, barbiturates, benzodiazepines, and other substances as may be appropriate, based upon patient history and prevailing patterns of availability.

(7) Medication units:

(a) interested applicants shall submit to the BHSD for approval to add a medication unit to their existing registration:

(i) a written letter of intent that demonstrates how this service will increase access to methadone in rural communities and avoid duplication with other OTP services;

(ii) standard operating procedure;

(iii) approval from the drug enforcement administration;

(iv) approval from the NM board of pharmacy; and

(v) application to SAMHSA/CSAT following BHSD approval.

(b) BHSD shall approve or deny the application within 30 working days of submission, unless the BHSD and applicant mutually agree to extend the application review period.

(c) BHSD may require the applicant to provide additional written or verbal information in order to reach its decision. Such further information shall be considered an integral part of the application and may extend the application review period.

(d) the following services may be provided where space allows for quality patient care in mobile medication units, assuming compliance with all applicable federal, state, and local law:

(i) administering and dispensing medications for opioid use disorder treatment;

(ii) collecting samples for drug testing or analysis;

(iii) dispensing of take-home medications;

(iv) in units that provide appropriate privacy and adequate space, intake/initial psychosocial and appropriate medical assessments (with a full physical examination to be completed or provided within 14-days of admission);

(v) initiating methadone or buprenorphine after an appropriate medical assessment has been performed;

(vi) in units that provide appropriate privacy and have adequate space, other OTP services, such as counseling, may be provided directly or when permissible through use of telehealth services.

(e) any required services not provided in mobile and non-mobile medication units must be conducted at the OTP, including medical, counseling, vocational, educational, and other assessment, and treatment services (42 CFR 8.12(f)(1)).

(8) Take home medication: active OTP recipients, regardless of the length of time in treatment, may receive take home doses for days during which the clinic is closed including one weekend day as well as state and federal holidays. Beyond the standing approval to allow take home doses when the clinic is closed OTP decisions on dispensing medication for opioid use disorder (MOUD) to recipients for unsupervised use shall be determined by an appropriately licensed OTP medical practitioner or the medical director.

(a) the OTP medical practitioner or medical director shall consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:

(i) absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;

(ii) regularity of attendance for supervised medication administration;

(iii) absence of serious behavioral problems that endanger the patient, the public or others;

(iv) absence of known recent diversion activity;

(v) whether take-home medication can be safely transported and stored; and

(vi) any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

(b) the program sponsor shall ensure that policies and procedures are developed, implemented, and complied with for the use of take-home medication and include:

(i) criteria for determining when a patient is ready to receive take-home medication;

(ii) criteria for when a patient's take-home medication is increased or decreased;

(iii) a requirement that take-home medication be dispensed according to federal and state law;

(iv) a requirement that the program medical director review a patient's take-home medication regimen at intervals of no less than 90 days and adjust the patient's dosage, as needed;

(v) procedures for safe handling and secure storage of take-home medication in a patient's home; and

(vi) criteria and duration of allowing a physician to prescribe a split medication regimen.

(c) during the first 14 days of treatment, the take-home supply is limited to seven days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to seven days, but decisions must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(d) from 15 days of treatment, the take-home supply is limited to 14 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 14 days, but this determination must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(e) from 31 days of treatment, the take-home supply to a patient is not to exceed 28 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 28 days, but this determination must be based on the criteria listed in Subparagraph (a) of Paragraph (8) of Subsection D of 8.321.2.31 NMAC.

(f) a program sponsor shall ensure that a patient receiving take-home medication receives:

(i) take home medication in a child-proof container: and

(ii) written and verbal information regarding the recipient's responsibility in the protection and security of take-home mediation.

(g) the rationale underlying the decision to provide or withdraw unsupervised doses of methadone must be documented in the patient's clinical record.

E. Non-covered services: Blood samples collected and sent to an outside laboratory.

F. Reimbursement:

(1) The bundled reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, and urine dipstick testing conducted within the agency.

(2) Other services performed by the agency as listed below are reimbursed separately and are required by (42 CFR Part 8.12 (f)), or its successor.

(a) a narcotic replacement or agonist drug item other than methadone that is administered or dispensed;

(b) behavioral health prevention and education services to affect knowledge, attitude, or behavior can be rendered by a licensed substance use disorder associate or certified peer support worker in addition to independently licensed practitioners;

(c) outpatient therapy other than substance use disorder and HIV counseling required by (42 CFR Part 8.12 (f)) is reimbursable when rendered by a MAD approved independently licensed provider that meets Subsection H of 8.321.2.9 NMAC;

(d) an eligible recipient's initial medical examination, which may be conducted in person or via telehealth when rendered by a MAD enrolled licensed practitioner who meets 8.310.2 and 8.310.3 NMAC requirements;

(e) full medical examination, prenatal care and gender specific services for a pregnant recipient; if they are referred to a provider outside the agency, payment is made to the provider of the service;

(f) medically necessary services provided beyond those required by (42 CFR Part 8.12 (f)), to address the medical issues of the eligible recipient; see 8.310.2 and 8.310.3 NMAC;

(g) the quantity of service billed in a single day can include, in addition to the drug items administered that day, the number of take-home medications dispensed that day; and

(h) guest dosing can be reimbursed at medicaid-enrolled agencies per 7.32.8 NMAC. Arrangements must be confirmed prior to sending the patient to the receiving clinic.

(3) For an IHS, tribal 638 facility or any other "Indian Health Care Provider (IHCP)" defined in 42 Code of Federal Regulations Section

(4) For a FQHC, MAD considers the bundled OTP services to be outside the FQHC all-inclusive rate and is therefore reimbursed at the MAD fee schedule utilizing the appropriate claim form designated by MAD; see 8.310.12 NMAC. Non-bundled services may be billed at the FQHC rate.

[8.321.2.31 NMAC - Rp, 8.321.2.30 NMAC, 12/10/2024]

8.321.2.32 PARTIAL HOSPITALIZATION SERVICES: To help an eligible recipient receive the level of services needed, MAD pays for partial hospitalization services furnished by an acute care or freestanding psychiatric hospital. Partial hospitalization programs (PHP) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of clinical services. They are designed to stabilize deteriorating conditions or avert inpatient admissions or can be a step-down strategy for individuals with SMI, SUD or SED who have required inpatient admission. The environment is highly structured, is time-limited and outcome oriented for recipients experiencing acute symptoms or exacerbating clinical conditions that impede their ability to function on a day-to-day basis. Program objectives focus on ensuring important community ties and closely resemble the real-life experiences of the recipients served.

A. Eligible providers and practitioners: In addition to the requirements found in Subsections A and B of 8.321.2.9 NMAC, an eligible provider includes a facility joint commission accredited, and licensed and certified by DOH or the comparable agency in another state.

(1) The program team must include:

(a) registered nurse;

(b) RLD board approved clinical supervisor that is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician; and

(c) licensed behavioral health practitioners.

(2) The team may also include:

(a) physician assistants;

(b) certified peer support workers;

(c) certified family peer support workers;

(d) licensed practical nurses;

(e) mental health technicians.

B. Coverage criteria: MAD covers only those services which meet the following criteria:

(1) Services that are ordered by a psychiatrist or licensed Ph.D.

(2) Partial hospitalization is a voluntary, intensive, structured and medically staffed, psychiatrically supervised treatment program with an interdisciplinary team intended for stabilization of acute psychiatric or substance use symptoms and adjustment to community settings. The services are essentially of the same nature and intensity, including medical and nursing services, as would be provided in an inpatient setting, except that the recipient is in the program less than 24-hours a day, and it is a time-limited program.

(3) A history and physical (H&P) must be conducted within 24 hours of admission. If the eligible recipient is a direct admission from an acute or psychiatric hospital setting, the program may elect to obtain the H&P in lieu of completing a new H&P. In this instance, the program physician's signature indicates the review and acceptance of the document. The H&P may be conducted by a clinical nurse specialist, a clinical nurse practitioner, a physician assistant, or a physician.

(4) An interdisciplinary biopsychosocial assessment within seven days of admission including alcohol and drug screening. A full substance use assessment is required if alcohol and drug screening indicate the need. If the individual is a direct admission from an acute psychiatric hospital setting, the program may elect to obtain and review this assessment in lieu of completing a new assessment.

(5) Services are furnished under an individualized treatment plan established within seven days of initiation of service by the psychiatrist, together with

the program's team of professionals, and in consultation with recipients, parents, legal guardian(s) or others who participate in the recipient's care. The plan must state the type, amount, frequency and projected duration of the services to be furnished and indicate the diagnosis and anticipated goals. The treatment plan must be reviewed and updated by the interdisciplinary team every 15 days.

(6) Documentation must be sufficient to demonstrate that coverage criteria are met, including:

(a) Daily documentation of treatment interventions which are outcome focused and based on the comprehensive assessment or psychiatric diagnostic evaluation, treatment goals, culture, expectations, and needs as identified by the recipient, family, or other caregivers.

(b) Supervision and periodic evaluation of the recipient, either individually or in a group, by the psychiatrist or psychologist to assess the course of treatment. At a minimum, this periodic evaluation of services at intervals indicated by the condition of the recipient must be documented in the recipient's record.

(c) Medical justification for any activity therapies, recipient education programs and psychosocial programs.

(7) Treatment must be reasonably expected to improve the eligible recipient's condition or designed to reduce or control the eligible recipient's psychiatric symptoms to prevent relapse or hospitalization and to improve or maintain the eligible recipient's level of functions. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement.

(8) For recipients in elementary and secondary school, educational services must be coordinated with the recipient's school system.

C. Identified population:

(1) Recipients admitted to a PHP shall be under the care of a psychiatrist who certifies the need for partial hospitalization. The recipient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a SMI, SED or moderate to severe SUD which severely interferes with multiple areas of daily life, including social, vocational, or educational functioning. Such dysfunction generally is of an acute nature;

(2) Recipients must have an adequate support system to sustain/maintain themselves outside the PHP;

(3) Recipients 19 and over with a serious mental illness including substance use who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment; or

(4) Recipients five to 18 with severe emotional disturbances including substance use disorders who can be safely managed in the community with high intensity therapeutic intervention more intensive than outpatient services but are at risk of inpatient care without this treatment.

D. Covered services and service limitations: A program of services must be furnished by a MAD enrolled provider delivering partial hospitalization to receive reimbursement from MAD. Payment for performance of these services is included in the facility's reimbursement rate:

(1) regularly scheduled structured counseling and therapy sessions for an eligible recipient, their family, group or multifamily group based on individualized needs furnished by licensed behavioral health professionals, and, as specified in the treatment plan;

(2) educational and skills building groups furnished by the program team to promote recovery;

(3) age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management;

(4) drugs and biologicals that cannot be self-administered and are furnished for therapeutic management;

(5) assistance to the recipient in self-administration of medication in compliance with state policies and procedures;

(6) appropriate staff available on a 24-hour basis to respond to crisis situations, evaluate the severity of the situation, stabilize the recipient make referrals as necessary, and provide follow-up;

(7) consultation with other professionals or allied caregivers regarding a specific recipient;

(8) coordination of all non-medical services, including transportation needed to accomplish a treatment objective;

(9) therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients; and

(10) discharge planning and referrals as necessary to community resources, supports, and providers in order to promote a recipient's return to a higher level of functioning in the least restrictive environment.

E. Non-covered services: Partial hospitalization services are subject to the limitations and coverage restrictions which exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for all general non-covered MAD behavioral health services or activities. MAD does not cover the following specific services with partial hospitalization:

(1) meals;

(2) transportation by the partial hospitalization provider;

(3) group activities or other services which are primarily recreational or diversional in nature;

(4) a program that only monitors the management of medication for recipients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a partial hospitalization program;

(5) actively homicidal or suicidal ideation that would not be safely managed in a PHP;

(6) formal educational and vocational services related to traditional academic subjects or vocational training; non-formal education services can be covered if they are part of an active treatment plan for the eligible recipient; see 42 CFR Section 441.13(b); or

(7) services to treat social maladjustments without manifest psychiatric disorders, including occupational maladjustment, marital maladjustment, and sexual dysfunction.

F. Prior authorization: Prior authorization is not required for this service unless the length of stay exceeds 45 days, at which time continued stay must be prior authorized (PA) from MAD or its UR contractor; or applicable MCO. Request for authorization for continued stay must state evidence of the need for the acute, intense, structured combination of services provided by a PHP, and must address the continuing serious nature of the recipient's psychiatric condition requiring active treatment in a PHP and include expectations for imminent improvement. Control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization are acceptable expectations of improvement. The request for authorization must also specify that a lower level of outpatient services would not be advised, and why, and that the recipient may otherwise require inpatient psychiatric care in the absence of continued stay in the PHP. The request describes:

(1) the recipient's response to the therapeutic interventions provided by the PHP;

(2) the recipient's psychiatric symptoms that continue to place the recipient at risk of hospitalization; and

(3) treatment goals for coordination of services to facilitate discharge from the PHP. See Subsection F of 8.321.2.9 NMAC for MAD general prior authorization requirements.

G. Reimbursement: A provider of partial hospitalization services must submit claims for reimbursement on the UB claim form or its successor. See 8.302.2 NMAC and Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements. Specific to partial hospitalization services:

(1) Freestanding psychiatric hospitals are reimbursed at an interim percentage rate established by HCA to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principles using the Title XVIII (medicare) principles cost methodology, MAD reduces the medicare allowable costs by three percent. For partial hospitalization services that are not cost settled, such as general acute care hospitals, payments are made at the outpatient hospital prospective levels, when applicable, on the procedure codes (see Subsection E of 8.311.2.15 NMAC).

(2) The payment rate is at a per diem representing eight hours, which is billed fractions of .25, .5, or .75 units to represent two, four, or six hours when applicable.

(3) Any professional services are billed and reimbursed to the provider under a separate professional component number, all costs for these services must be removed from the hospital cost report prior to cost settlement or rebasing.

(4) Services performed by a physician or Ph.D. psychologist are billed separately as a professional service. Other services performed by employees or contractors to the facility are included in the per diem rate which may be billed separately are:

(a) performance of necessary evaluations and psychological testing for the development of the treatment plan, while ensuring that evaluations already performed are not repeated;

(b) physical examination and any resultant medical treatments, while ensuring that a physical examination already performed is not repeated;

(c) any medically necessary occupational or physical therapy; and

(d) other professional services not rendered as part of the program.

[8.321.2.32 NMAC - Rp, 8.321.2.31 NMAC, 12/10/2024]

8.321.2.33 PSYCHOSOCIAL REHABILITATION SERVICES: To help an adult eligible recipient 18 years and older who met the criteria of SMI, MAD pays for psychosocial rehabilitation services (PSR). PSR is an array of services offered in a group setting through a clubhouse or a classroom and is designed to help an individual to capitalize on personal strengths, to develop coping strategies and skills to deal with deficits, and to develop a supportive environment in which to function as independently as possible. Psychosocial rehabilitation intervention is intended to be a transitional level of care based on the individual's recovery and resiliency goals. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Agency staff must possess the education, skills, abilities, and experience to perform the activities that comprise the full spectrum of PSR services.

See Subsection A of 8.321.2.9 NMAC for MAD general provider requirements. PSR agencies must:

(a) have provided a minimum of three years of CCSS services; and

(b) be approved through the application process described in the BH policy and billing manual.

(2) Staffing requirements:

(a) both clinical services and supervision by licensed practitioners must be in accord with their respective licensing board regulations.

(b) PSR services must meet a staff ratio sufficient to ensure that patients have reasonable and prompt access to services.

(c) in both clubhouse and classroom settings, the entire staff works as a team.

(d) the team must include a clinical supervisor/team lead and can include the following:

(i) certified peer support workers;

(ii) certified family support workers;

(iii) community support workers; and

(iv) other HIPAA trained individuals working under the direct supervision of the clinical supervisor.

(e) minimum qualifications for the clinical supervisor/team lead:

(i) independently licensed behavioral health professional (i.e. psychiatrist, psychologist, LISW, LPCC, LMFT, psychiatrically certified (CNS) practicing under the scope of their NM license;

(ii) have one year of demonstrated supervisory experience;

(iii) demonstrated knowledge and competence in the field of psychosocial; rehabilitation; and

(iv) an attestation of training related to providing clinical supervision of non-clinical staff.

B. Coverage criteria:

(1) MAD covers only those PSR services are medically necessary to meet the individual needs of the eligible recipient, as delineated in their treatment plan. Medical necessity is based upon the eligible recipient's level of functioning as affected by their SMI. The PSR services are limited to goals which are individually designed to accommodate the level of the eligible recipient's functioning, and which reduce the disability and restore the recipient to their best possible level of functioning.

(2) These services must be provided in a facility-based setting, either in a clubhouse model or a structured classroom.

(3) PSR services must be identified and justified in the individual's treatment plan. Recipients shall participate in PSR services for those activities that are identified in the treatment plan and are tied directly to the recipient's recovery and resiliency plan/goals.

(4) Specific service needs (e.g., household management, nutrition, hygiene, money management, parenting skills, etc.) must be identified in the individual's treatment plan.

C. Identified population:

(1) An eligible recipient 18 years or older meeting the criteria for SMI and for whom the medical necessity for PSR services was determined.

(2) Adults diagnosed with co-occurring SMI and SUD and for whom the medical necessity for PSR services was determined.

(3) A resident in an institution for mental illness is not eligible for this service**.**

D. Covered services: The psychosocial intervention (PSI) program must include the following major components: basic living skills development; psychosocial skills training; therapeutic socialization; and individual empowerment.

(1) Basic living skills development activities address the following areas, including but not limited to:

(a) basic household management;

(b) basic nutrition, health, and personal care including hygiene;

(c) personal safety;

(d) time management skills;

(e) money management skills;

(f) how to access and utilize transportation;

(g) awareness of community resources and support in their use;

(h) child care/parenting skills;

(i) work or employment skill-building; and

(j) how to access housing resources.

(2) Psychosocial skills training activities address the following areas:

(a) self-management;

(b) cognitive functioning;

(c) social/communication; and

(d) problem-solving skills.

(3) Therapeutic socialization activities address the following areas:

(a) understanding the importance of healthy leisure time;

(b) accessing community recreational facilities and resources;

(c) physical health and fitness needs;

(d) social and recreational skills and opportunities; and

(e) harm reduction and relapse prevention strategies (for individuals with co-occurring disorders).

(4) Individual empowerment activities address the following areas:

(a) choice;

(b) self-advocacy;

(c) self-management; and

(d) community integration.

E. Non-covered services: PSR services are subject to the limitations and coverage restrictions which exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for all general non-covered MAD behavioral health services or activities. Specifically, PSR cannot be billed concurrently when the recipient is a resident of an institution for the mentally ill.

F. Prior authorization: No prior authorization is required. To determine retrospectively if the medical necessity for the service has been met, the following factors are considered:

(1) recipient assessment;

(2) recipient diagnostic formation;

(3) recipient treatment plans; and

(4) compliance with 8.321.2 NMAC.

G. Reimbursement: Claims for reimbursement are submitted on the CMS-1500 claim form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC.

[8.321.2.33 NMAC - Rp, 8.321.2.32 NMAC, 12/10/2024]

8.321.2.34 RECOVERY SERVICES (MCOs only): Recovery services are peer-to-peer support for managed care members to develop and enhance wellness and health care practices. Recovery services promote self-responsibility through recipients learning new health care practices from a peer who has had similar life challenges and who has developed self-efficacy in using needed skills. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Staffing requirements:

(1) all staff must possess a current and valid NM driver's license;

(2) clinical supervisor:

(a) licensed as a RLD board approved clinical supervisor independent practitioner (i.e., psychiatrist, psychologist, LISW, LPCC, LMFT, CNP, CNS); and

(b) two years relevant experience with the target population; and

(c) one year demonstrated supervisory experience; and

(d) expertise in both mental health and SUD treatment services; and

(e) supervision must be conducted in accord with respective licensing board regulations.

(3) certified peer support workers; and

(4) certified family specialists.

(5) Group ratios should be sufficient to ensure that patients have reasonable and prompt access to services at the required levels of frequency and intensity within the practitioner's scope of practices.

B. Coverage criteria: Services occur individually or with consumers who support each other to optimize learning new skills. This skill enhancement then augments the effectiveness of other treatment and recovery support initiatives.

(1) Admissions criteria: Consumer has been unable to achieve functional use of natural and community support systems to effectively self-manage recovery and wellness.

(2) Continuation of services criteria: Consumer has made progress in achieving use of natural and community support systems to effectively self-manage recovery and wellness but continues to need support in developing those competencies.

(3) Discharge criteria: Consumer has achieved maximum use of natural and community support systems to effectively self-manage recovery and wellness.

C. Identified population:

(1) Children experiencing serious emotional/ neurobiological/behavioral disorders;

(2) Adults with SMI; and

(3) Individuals with chronic SUD; or individuals with a co-occurring disorder (mental illness and SUD) or dually diagnosed with a primary diagnosis of mental illness.

D. Covered services:

(1) This service will particularly focus on the individual's wellness, ongoing recovery and resiliency, relapse prevention, and chronic disease management.

(2) Recovery services support specific recovery goals through:

(a) use of strategies for maintaining the eight dimensions of wellness;

(b) creation of relapse prevention plans;

(c) learning chronic disease management methods; and

(d) identification of linkages to ongoing community supports.

(3) Activities must support the individual's recovery goals. There must be documented evidence of the individual identifying desired recovery goals and outcomes and incorporating them into a recovery services treatment plan.

(4) Recovery services activities include, but are not limited to:

(a) screening, engaging, coaching, and educating.

(b) emotional support that demonstrates empathy, caring, or concern to bolster the person's self-esteem and confidence.

(c) sharing knowledge and information or providing life skills training.

(d) provision of concrete assistance to help others accomplish tasks.

(e) facilitation of contacts with other people to promote learning of social and recreational skills, create community and acquire a sense of belonging.

(5) Recovery services can be delivered in an individual or group setting.

E. Non-covered services: This service may not be billed in conjunction with:

(1) multi-systemic therapy (MST);

(2) assertive community treatment (ACT);

(3) partial hospitalization;

(4) transitional living services (TLS); or

(5) treatment foster care (TFC).

[8.321.2.34 NMAC - Rp, 8.321.2.33 NMAC, 12/10/2024]

8.321.2.35 SCREENING, BRIEF INTERVENTION & REFERRAL TO TREATMENT (SBIRT): SBIRT is a community-based practice designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. Through early identification in a medical setting, SBIRT services expand and enhance the continuum of care and reduce costly health care utilization. The primary objective is the integration of behavioral health with medical care. SBIRT is delivered through a process consisting of universal screening, scoring the screening tool and a warm hand-off to a SBIRT trained professional who conducts a face-to-face brief intervention for positive screening results. If the need is identified for additional treatment, the staff member will refer to behavioral health services. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

A. Eligible providers and practitioners:

(1) Providers may include the following agency types that have completed the state approved SBIRT training:

(a) primary care offices including FQHCs, IHS 638 tribal facilities and any other "Indian Health Care Provider (IHCP)" defined in 42 Code of Federal Regulations Section);

(b) patient centered medical homes;

(c) urgent care centers;

(d) hospital outpatient facilities;

(e) emergency departments;

(f) rural health clinics;

(g) specialty physical health clinics;

(h) school based health centers; and

(i) nursing facilities.

(2) Rendering practitioners must work in the approved agencies defined in Paragraph (1) of Subsection A of 8.321.2.36 NMAC and may include:

(a) licensed nurse trained in SBIRT;

(b) advance practice registered nurse trained in SBIRT;

(c) behavioral health practitioner at all educational levels trained in SBIRT;

(d) behavioral health interns under the supervision of a board approved clinical supervisor;

(e) certified peer support worker, certified family peer support worker, or certified youth peer support specialist trained in SBIRT;

(f) community health worker trained in SBIRT;

(g) licensed physician assistant trained in SBIRT;

(h) physician trained in SBIRT;

(i) home health agency trained in SBIRT

(j) nurse home visit EPSDT;

(k) medical assistant trained in SBIRT; and

(l) community health representative in tribal clinics trained in SBIRT.

B. Coverage criteria:

(1) screening shall be universal for recipients being seen in a medical setting;

(2) referral relationships with mental health agencies and practices are in place;

(3) utilization of approved screening tool specific to age described in the BH policy and billing manual;

(4) all participating providers and practitioners are trained in SBIRT through a state approved SBIRT training. See details in the BH policy and billing manual.

C. Identified population:

(1) MAD recipients 11 to 17 years of age, in accordance with state laws related to adolescent consent and confidentiality.

(2) MAD recipient adolescents 18 years and older.

D. Covered services:

(1) SBIRT screening with negative results eligible for only screening component;

(2) SBIRT screening with positive results for alcohol, or other drugs, with or without co-occurring depression, or anxiety, or trauma are eligible for:

(a) screening; and

(b) brief intervention and referral to behavioral health treatment, if needed.

E. Reimbursement:

(1) Screening services do not require a diagnosis; brief interventions can be billed with a provisional diagnosis.

(2) See BH policy and billing manual for coding and billing instruction.

[8.321.2.35 NMAC - Rp, 8.321.2.34 NMAC, 12/10/2024]

8.321.2.36 SMOKING CESSATION COUNSELING: See 8.310.2 NMAC for a detailed description of tobacco cessation services and approved behavioral health providers.

[8.321.2.36 NMAC - Rp, 8.321.2.35 NMAC, 12/10/2024]

8.321.2.37 SUPPORTIVE HOUSING PRE-TENANCY AND TENANCY SERVICES (PSH-TSS) (MCO only): MAD pays for coverage for permanent supportive housing pre-tenancy and tenancy support services (PSH-TSS) to an eligible recipient enrolled in a managed care organization to facilitate community integration and contribute to a holistic focus on improved health outcomes, to reduce the negative health impact of precarious housing and homelessness, and to reduce costly inpatient health care utilization. Services include, but are not limited to, pre-tenancy services including individual housing support and crisis planning, tenancy orientation and landlord relationship services as well as tenancy support services to identify issues that undermine housing stability and coaching, education and assistance in resolving tenancy issues for an eligible recipient who has a serious mental illness and is enrolled in a medicaid managed care.

A. Eligible providers and practitioners:

(1) Any clinic, office or agency providing permanent supportive housing under the HCA linkages program administered by BHSD.

(2) Behavioral health practitioners employed or contracted with such facilities including:

(a) behavioral health professional licensed in the state of NM; and

(b) certified peer support workers or certified family peer support workers.

B. Coverage criteria:

(1) Enrollment in the linkages permanent supportive housing program.

(2) An assessment documenting serious mental illness.

C. Eligible recipients: Individuals with serious mental illness.

D. Covered services:

(1) Pre-tenancy services, including:

(a) screening and identifying preferences and barriers related to successful tenancy;

(b) developing an individual housing support plan and housing crisis plan;

(c) ensuring that the living environment is safe and ready for move-in;

(d) tenancy orientation and move-in assistance;

(e) assistance in securing necessary household supplies; and

(f) landlord relationship building and communication.

(2) Tenancy support services, including:

(a) early identification of issues undermining housing stability, including member behaviors;

(b) coaching the member about relationships with neighbors, landlords and tenancy conditions;

(c) education about tenant responsibilities and rights;

(d) assistance and advocacy in resolving tenancy issues;

(e) regular review and updates to housing support plan and housing crisis plan; and

(f) linkages to other community resources for maintaining housing.

E. Duration: The PSH-TSS benefit is available to an eligible member for the duration of the member's enrollment in a linkages program, ceasing when the client leaves the program.

F. Reimbursement: See Subsection H of 8.321.9 NMAC for MAD behavioral health general reimbursement requirements. See the BH policy and billing manual for reimbursement specific to PSH-TSS. These services do not include tenancy assistance in the form of rent or subsidized housing.

[8.321.2.37 NMAC - Rp, 8.321.2.36 NMAC, 12/10/2024]

8.321.2.38 TREATMENT FOSTER CARE I and II: MAD pays for medically necessary services furnished to an eligible recipient under 21 years of age who has an identified need for treatment foster care (TFC) and meets the TFC I or TFC II level of care (LOC) as part of the EPSDT program. MAD covers those services included in the eligible recipient's individualized treatment plan which is designed to help them develop skills necessary for successful reintegration into their family or transition back into the community. TFC I agency provides therapeutic services to an eligible recipient who is experiencing emotional or psychological trauma and who would optimally benefit from the services and supervision provided in a TFC I setting. The TFC II agency provides therapeutic family living experiences as the core treatment service to which other individualized services can be added. The need for TFC I and II services must be identified in the tot to teen health check or other diagnostic evaluation furnished through the eligible recipient's health check referral.

A. Eligible agencies: In addition to the requirements of

Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing TFC services to an eligible recipient, the agency must be a CYFD certified TFC agency per 7.20.11 NMAC and be licensed per 8.26.4 and 8.26.5 NMAC as a child placement agency by CYFD protective services. In lieu of NM CYFD licensure and certification, an out-of-state TFC agency must have equivalent accreditation and be licensed in its own state as a TFC agency.

B. Coverage criteria:

(1) The treatment foster care agency provides intensive support, technical assistance, and supervision of all treatment foster parents.

(2) A TFC I and II parent is either employed or contracted by the TFC agency and receives appropriate training and supervision by the TFC agency.

(3) Placement does not occur until after a comprehensive assessment of how the prospective treatment foster family can meet the recipient's needs and preferences, and a documented determination by the agency that the prospective placement is a reasonable match for the recipient, which includes clinical rationale.

(4) An initial treatment plan must be developed within 72 hours of admission and a comprehensive treatment plan must be developed within 14 calendar days of the eligible recipient's admission to a TFC I or II program. See the BH policy and billing manual for the specific requirements of a TFC treatment plan.

(5) The treatment team must review the treatment plan every 30 calendar days.

(6) TFC families must have one parent readily accessible at all times, cannot schedule work when the eligible recipient is normally at home, and is able to be physically present to meet the eligible recipient's emotional and behavioral needs.

(7) In the event the treatment foster parents request a treatment foster recipient be removed from their home, a treatment team meeting must be held and an agreement made that a move is in the best interest of the involved recipient. Any treatment foster parent(s) who demands removal of a treatment foster recipient from their home without first discussing with and obtaining consensus of the treatment team, may have their license revoked.

(8) A recipient eligible for treatment foster care services, level I or II, may change treatment foster homes only under the following circumstances:

(a) an effort is being made to reunite siblings; or

(b) a change of treatment foster home is clinically indicated, as documented in the client's record by the treatment team.

C. Identified population:

(1) TFC I services are for an eligible recipient who meets the following criteria:

(a) is at risk for placement in a higher level of care or is returning from a higher level of care and is appropriate for a lower level of care; or

(b) has complex and difficult psychiatric, psychological, neurobiological, behavioral, psychosocial problems; and

(c) requires and would optimally benefit from the behavioral health services and supervision provided in a treatment foster home setting.

(2) TFC II services are for an eligible recipient who meets the following criteria:

(a) has successfully completed treatment foster care services level I (TFC I), as indicated by the treatment team; or

(b) requires the initiation or continuity of treatment and support of the treatment foster family to secure or maintain therapeutic gains; or

(c) requires this treatment modality as an appropriate entry level service from which the client will optimally benefit.

(3) An eligible recipient has the right to receive services from any MAD TFC enrolled agency of their choice.

D. Covered services: The family living experience is the core treatment service to which other individualized services can be added, as appropriate to meet the eligible recipient's needs.

(1) The TFC parental responsibilities include, but are not limited to:

(a) meeting the recipient's base needs, and providing daily care and supervision;

(b) participating in the development of treatment plans for the eligible recipient by providing input based on their observations;

(c) assuming the primary responsibility for implementing the in-home treatment strategies specified in the eligible recipient's treatment plan;

(d) recording the eligible recipient's information and documentation of activities, as required by the TFC agency and the standards under which it operates;

(e) assisting the eligible recipient with maintaining contact with their family and enhancing that relationship;

(f) supporting efforts specified by the treatment plan to meet the eligible recipient's permanency planning goals;

(g) reunification with the recipient's family. The treatment foster parents work in conjunction with the treatment team toward the accomplishment of the reunification objectives outlined in the treatment plan;

(h) assisting the eligible recipient obtain medical, educational, vocational and

other services to reach goals identified in treatment plan;

(i) ensuring proper and adequate supervision is provided at all times. Treatment teams determine that all out-of-home activities are appropriate for the recipient's level of need, including the need for supervision; and

(j) working with all appropriate and available community-based resources to secure services for and to advocate for the eligible recipient.

(2) The treatment foster care agency provides intensive support, technical assistance, and supervision of all treatment foster parents. The following services must be furnished by both TFC I and II agencies unless specified for either I or II. Payment for performance of these services is included in the TFC agency's reimbursement rate:

(a) facilitation, monitoring and documenting of treatment of TFC parents initial and ongoing training;

(b) providing support, assistance and training to the TFC parents;

(c) providing assessments for pre-placement and placement to determine the eligible recipient's placement is therapeutically appropriate;

(d) ongoing review of the eligible recipient's progress in TFC and assessment of family interactions and stress;

(e) ongoing treatment planning as defined in Subsection G of 8.321.2.9 NMAC and treatment team meetings;

(f) provision of individual, family or group psychotherapy to recipients as described in the treatment plan. The TFC therapist is an active treatment team member and participates fully in the treatment planning process;

(g) family therapy is required when client reunification with their family is the goal;

(h) ensuring facilitation of age-appropriate skill development in the areas of household management, nutrition, physical and emotional health, basic life skills, time management, school attendance, money management, independent living, relaxation techniques and self-care techniques for the eligible recipient;

(i) providing crisis intervention on call to treatment foster parents, recipients and their families on a 24-hour, seven days a week basis including 24-hour availability of appropriate staff to respond to the home in crisis situations;

(j) assessing the family's strengths, needs and developing a family treatment plan when an eligible recipient's return to their family is planned;

(k) conducting a private face-to-face visit with the eligible recipient within the first two weeks of TFC I placement and at least twice monthly thereafter by the treatment coordinator;

(l) conducting a face-to-face interview with the eligible recipient's TFC parents within the first two weeks of TFC I placement and at least twice monthly thereafter by the treatment coordinator;

(m) conducting at a minimum one phone contact with the TFC I parents weekly; phone contact is not necessary in the same week as the face-to-face contact by the treatment coordinator;

(n) conducting a private face-to face interview with the eligible recipient's TFC II parent within the first two weeks of TFC II placement and at least once monthly thereafter by the treatment coordinator;

(o) conducting a face-to-face interview with the eligible recipient's TFC II parent within the first two weeks of TFC II placement and at least once monthly thereafter by the treatment coordinator; and

(p) conducting at a minimum one phone contact with the TFC II parents weekly; phone contact is not necessary in the same week as the face-to-face contact by the treatment coordinator.

E. Non-covered service: TFC I and II services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for all non-covered MAD behavioral health services or activities. Specific to TFC I and II services MAD does not cover:

(1) room and board;

(2) formal educational or vocational services related to traditional academic subjects or vocational training;

(3) respite care; and

(4) CCSS except as part of the discharge planning from either the eligible recipient's TFC I or II placement.

F. Prior authorization: Before any TFC service is furnished to an eligible recipient, prior authorization is required from MAD or its UR contractor. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

G. A TFC agency must submit claims for reimbursement on the CMS-1500 form or its successor. See Subsection H of 8.321.2.9 NMAC for MAD general reimbursement requirements and see 8.302.2 NMAC. [8.321.2.38 NMAC - Rp, 8.321.2.37 NMAC, 12/10/2024]

8.321.2.39 THERAPEUTIC INTERVENTIONS: MAD provides coverage for therapeutic intervention services rendered to individuals with mental health disorders. The mental health services rendered shall be necessary to reduce the disability resulting from mental illness and to restore the individual to their best possible functioning level in the community. Therapeutic interventions are the

following evidence-based practices delivered by qualified licensed mental health practitioners: trauma-focused cognitive behavioral therapy (TF-CBT); eye movement desensitization and reprocessing (EMDR); and dialectical behavior therapy (DBT).

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing TF-CBT, EMDR, or DBT services, an agency must be approved through the application process described in the BH policy and billing manual and hold an acceptable certification or licensure for the specific EBP identified above. The following mental health practitioners who are licensed in the state of NM to diagnose and treat behavioral health, acting within the scope of all applicable state laws and their professional license, may provide the above evidence-based practices if certification is obtained from the listed source:

(1) licensed psychologists;

(2) licensed clinical social workers (LCSWs);

(3) licensed professional clinical counselors (LPCCs);

(4) licensed marriage and family therapists (LMFTs);

(5) licensed alcohol and drug abuse counselors (LADAC); and

(6) advanced practice registered nurses (APRN) (must be a nurse practitioner specialist in adult psychiatric & mental health, and family psychiatric & mental health or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice).

B. Additional provider requirements for DBT: DBT agencies must be able to provide 24-hours a day, seven days a week availability for skills coaching. Therapists must be independently licensed but may work with master's or bachelor's level staff with a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population that is, children or adolescents and their families. Unlicensed staff may not provide DBT therapy. Unlicensed staff may only provide service coordination and group therapy in conjunction with a trained licensed therapist. An active DBT team requires DBT certification of at least two certified treatment providers working collaboratively with one another using the DBT services as defined by the DBT services program selected by the state. DBT trainees and DBT care managers may be the second professional in a group setting where a DBT therapist is the group lead. In addition, while the DBT trainees and DBT care managers may bill for service coordination, they may not bill for DBT therapy. Only a licensed and trained DBT therapist may bill for DBT therapy.

C. Identified population: Individuals with mental health disorders. There is no age restriction for EMDR, or DBT. TF-CBT is limited to children under the age of 18 and their families. Services provided to family members or other supports are for the direct benefit of the medicaid recipient.

D. Covered services: Therapeutic interventions are services rendered to reduce disability resulting from mental illness and to restore the individual to their best possible functioning level in the community. Therapeutic interventions include:

(1) Trauma-focused cognitive behavioral therapy (TF-CBT): Is a combination of cognitive behavioral therapy, family therapy, and psychosocial education to address the effects of trauma using conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Trauma focus cognitive behavioral therapy certification program (tfcbt.org) is an acceptable certification. Any interventions involving parents and caregivers are for the direct benefit of the beneficiary.

(2) Eye movement desensitization and reprocessing (EMDR): An evidence-based psychotherapy that treats trauma-related symptoms. EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. The therapist guides the client to process the trauma by attending to emotionally disturbing material in brief, sequential doses, while at the same time focusing on an external stimulus. The most commonly used external stimulus in EMDR therapy is alternating eye movements; however, sounds or taps may be used as well. EMDRIA (EMDR International Association) sets the standards and requirements for EMDR therapy training. EMDRIA certifies individual clinical practitioners in the practice of EMDR therapy by ensuring all basic requirements, initial training, and ongoing certification are met (see www.emdria.org). EMDRIA establishes two levels of training for practitioners in EMDR therapy. For the purposes of providing EMDR therapy under NM medicaid, either level (EMDRIA approved basic training, or EMDR certification) are acceptable qualifications. The standard level of training, which allows a practitioner to provide EMDR therapy, is referred to as "EMDRIA approved basic training".

(3) Dialectical behavior therapy (DBT): A cognitive behavioral approach to treatment to teach individuals better management of powerful emotions, urges, and thoughts that can disrupt daily living if not addressed in a structured treatment approach. DBT-linehan board of certification is an acceptable qualification. This

evidence-based practice includes service coordination, individual, group, and family therapy. A DBT provider must include in their program individual DBT therapy, DBT skills groups, 24-hour coverage seven days per week availability for skills coaching, and a clinical consultation team.

E. Service exclusions and limitations: Therapeutic intervention services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services. All services provided while a person is a resident of an institution for mental disease (IMD) are considered content of the institutional service and are not otherwise reimbursable by medicaid. Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations. The following activities services shall be excluded from medicaid coverage and reimbursement of these evidence-based practices:

(1) Components that are not provided to, or directed exclusively toward, the treatment of the medicaid eligible individual.

(2) Services provided at a work site, which are job-oriented and not directly related to the treatment of the member's needs.

(3) These rehabilitation services shall not duplicate any other medicaid state plan service or service otherwise available to the member at no cost.

(4) Any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

F. Additional DBT service exclusions and limitations: DBT shall not be billed in conjunction with BH services by licensed and unlicensed individuals, other than medication management and psychological evaluation or assessment; and residential services, including therapeutic foster care and RTC services.

G. Reimbursement: Therapeutic intervention agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the agency receives instructions on how to access documentation, billing, and claims processing information. [8.321.2.39 NMAC - N, 12/10/2024]

8.321.2.40 FUNCTIONAL FAMILY THERAPY (FFT): To help eligible recipients receive behavioral health services to MAD pays for FFT services. FFT is an evidence-based, short term and intensive family-based and manual driven treatment program that has been successful in treating a wide range of problems affecting families in a wide range of multi-ethnic, multicultural, and geographic contexts.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing FFT services, an agency must hold a copy of FFT, LLC or FFT partners certification, or any of its approved subsidiaries and meet the state licensure and provider enrollment requirements for each FFT team. Additionally, the agency must complete the application process as described in the BH policy and billing manual. An active FFT team requires FFT certification of a clinical supervisor and at least two FFT certified treatment providers working collaboratively with one another using the FFT services as defined by the State. Providers must be engaged in training, consultation, and oversight by either of the following training entities: FFT LLC or FFT partners.

(1) The FFT program includes an assigned FFT team for each eligible recipient. The FFT team must include at minimum:

(a) master's level independently licensed behavioral health professional clinical supervision; see Subsection H of 8.321.2.9 NMAC;

(b) a licensed master's level behavioral health practitioner that is required to perform all FFT interventions; a bachelor's level behavioral health practitioner is limited to performing functions defined within the scope of their RLD practice board licensure or practice (see Subsection E of 8.321.2.9 NMAC);

(c) bachelor's level staff that has a degree in social work, counseling, psychology, or a related human services field and must have at least three years' experience working with the identified population of children, adolescents and their families. Bachelor's level staff may provide the non-clinical components of treatment including treatment planning, skill-building, and family psychoeducation but not family therapy; and

(d) staffing for FFT services is comprised of no more than one-third bachelor's level staff and, at minimum, two-thirds licensed master's level staff unless an exception is granted by FFT, LLC or FFT partners.

(2) Clinical supervision must include at a minimum:

(a) weekly supervision provided by an independently licensed master's level behavioral health practitioner (see Subsection C of 8.321.2.9 NMAC) who is FFT trained; this supervision, following the FFT supervisory protocol, is provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis; and

(b) one hour of local group supervision per week and one hour of telephone consultation per week with the FFT systems supervisor, provided to team members on topics directly related to the needs of the eligible recipient and their family on an ongoing basis.

(3) All clinical staff are required to participate in and complete a prescribed five-day FFT introductory training and subsequent quarterly trainings.

B. Identified population:

(1) FFT is provided to an eligible youth meeting medical necessity with serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance use. FFT is an evidence-based, short term and intensive family-based treatment. FFT program's goals are to: integrate families' voices in all phases of treatment; develop and grow in innovative, collaborative, dynamic and evidence-based practices; practice evidence-based programs in evidence-based ways to maintain model fidelity; evolve the model in a way that is responsive to the needs of families, communities, and agencies; and provide innovative, real-time cloud-based technology and training for predictability and outcomes.

(2) A co-occurring diagnosis of SUD shall not exclude an eligible recipient from the program.

C. Covered services and service limitations: FFT enrolls families with youth meeting medical necessity with serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance use. FFT services may be provided in both clinic-based and community-based settings. FFT service components include treatment planning; restoration of social skills which is available 24-hours a day, seven days a week; and family therapy and psychoeducation. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient.

(1) The following services must be furnished as part of the FFT service to be eligible for reimbursement:

(a) an initial assessment to identify the focus of the FFT intervention;

(b) therapeutic interventions with the eligible recipient and their family; and

(c) case management.

(2) FFT services are conducted by practitioners using the FFT team approach. The FFT team must have the ability to deliver services in various environments both clinic-based and community based.

(3) FFT interventions occur in three primary phases: engagement/motivation, behavior change, and generalization; each with measurable process goals and family skills that are the targets of intervention with the length of treatment covered based on medical necessity. Each phase has specific goals and practitioner skills associated with it. The specificity of the model allows for monitoring of treatment, training, and practitioner model adherence in ways that are not possible with other less specific treatment interventions.

D. Non-covered services: FFT services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

E. Reimbursement: FFT agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the FFT agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.40 NMAC - N, 12/10/2024]

8.321.2.41 HIGH FIDELITY WRAPAROUND (HFW): An intensive care coordination service designed as a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. HFW aligns with the children's system of care (SOC) approach in NM. HFW supports teams to effectively coordinate within the state's children's behavioral health service array including access to community supports and resources. When services are provided to family or other supports the service must be for the direct benefit of the medicaid recipient.

A. Eligible providers: In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing HFW an agency must complete the application process as described in the behavioral health billing and policy manual. HFW agencies must maintain a clinical director and program director or administrator.

(1) The HFW program includes an assigned HFW team for each eligible recipient. The HFW team includes:

(a) wraparound facilitator who has completed the requirements of the facilitator in training (FIT) track, obtained wraparound certification from the NM credentialing board for behavioral health professionals (NMCBBHP), and meets the educational requirements identified in the BH policy and billing manual;

(b) wraparound supervisor-coach who has completed the requirements of the facilitator in training (FIT) track, obtained wraparound certification from the NM credentialing board for behavioral health professionals (NMCBBHP), completed the requirements of the coach in training (CIT) track, and meets the educational requirements identified in the BH policy and billing manual; and

(c) a family peer support worker.

B. Identified population: individuals are eligible to receive HFW intensive care coordination if they meet the following criteria:

(1) children or youth with an SED diagnosis;

(2) functional impairment in two or more domains

identified by the child and adolescent needs and strengths (CANS) tool;

(3) involved in two or more systems such as special education, behavioral health, protective services or juvenile justice, or (for children aged 0-5) are at risk of such involvement; and

(4) are at risk or in an out of home placement.

C. Covered services include:

(1) Intensive care coordination through dedicated full-time care coordinators working with small numbers of children and families. The care coordinator is required to follow state guidelines described in the BH policy and billing manual for care of children with SED who are eligible for HFW. Care coordinators work in partnership with representatives of key stakeholder groups, including families, agencies, providers, and community representatives to plan, implement and oversee HFW coordination plans. Intensive care coordination includes, but is not limited to:

(a) functional, needs and strengths assessment and service planning;

(b) accessing and arranging for services, resources and supports;

(c) coordinating multiple services, levels of care, resources, supports and teams;

(d) conducting safety and stability planning and response;

(e) assisting children and families in meeting basic needs;

(f) advocating for children and families;

(g) monitoring progress; and

(h) conducting a team and strengths-based approach.

(2) Treatment planning: the individualized care coordination plans are developed by engaging with the beneficiary's family or caretakers and other members of the beneficiary's community. Such plans must be family and youth-driven, team-based, collaborative, individualized, and outcomes-based. The plan of care must address youth and family needs across domains of physical and behavioral health and social services.

D. Non-covered services: HFW services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

E. Reimbursement: HFW agencies must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the HFW agency receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.41 NMAC - N, 12/10/2024]

8.321.2.42 PEER SUPPORT SERVICES: Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders.

A. Eligible practitioners: Must be self-identified consumers who are in recovery from mental illness or substance use disorder. In addition to the requirements of Subsections A and B of 8.321.2.9 NMAC, in order to be eligible to be reimbursed for providing peer support services practitioners meet the following qualifications:

(1) Certified peer support workers (CPSW) must:

(a) complete the certification program offered through BHSD;

(b) be certified by the NM credentialing board for behavioral health professionals;

(c) complete 20 hours of initial training and 20 hours of education every subsequent year;

(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and

(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

(2) Certified family peer support workers (CFPSW) must:

(a) complete the certification program offered through CYFD;

(b) be certified by the NM credentialing board for behavioral health professionals;

(c) complete 20 hours of initial training and 20 hours of education every subsequent year;

(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and

(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

(3) Certified youth peer support specialists (CYPSS) must:

(a) complete the certification program offered through CYFD;

(b) be certified by the NM credentialing board for behavioral health professionals;

(c) complete 20 hours of initial training and 20 hours of education every subsequent year;

(d) be supervised by an independent practitioner or someone trained and certified to supervise peers; and

(e) services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

B. Non-covered services: Peer support services are subject to the limitations and coverage restrictions that exist for other MAD covered services. See Subsection G of 8.321.2.9 NMAC for general non-covered specialized behavioral health services.

C. Reimbursement: peer support providers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See Subsection E of 8.321.2.9 NMAC for MAD general reimbursement requirements and 8.302.2 NMAC. Once enrolled, the peer support provider receives instructions on how to access documentation, billing, and claims processing information.

[8.321.2.42 NMAC - N, 12/10/2024]

HISTORY OF 8.321.2 NAMC:

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

ISD 310.1700, EPSDT Services, filed 2/13/1980.
ISD 310.1700, EPSDT Services, filed 6/25/1980.
ISD Rule 310.1700, EPSDT Services, filed 10/22/1984.
MAD Rule 310.17, EPSDT Services, filed 5/1/1992.
MAD Rule 310.17, EPSDT Services, filed 7/14/1993.
MAD Rule 310.17, EPSDT Services, filed 11/12/1993.
MAD Rule 310.17, EPSDT Services, filed 12/17/1993.
MAD Rule 310.17, EPSDT Services, filed 3/14/1994.
MAD Rule 310.17, EPSDT Services, filed 6/15/1994.
MAD Rule 310.17, EPSDT Services, filed 11/30/1994.

History of Repealed Material:

MAC Rule 310.17, EPSDT Services, filed 11/30/1994 - Repealed effective 2/1/1995.
8.321.2 NMAC, Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals, filed 10/8/2010 - Repealed effective 1/1/2014.
8.321.3 NMAC, Accredited Residential Treatment Center Services, filed 2/17/2012 - Repeal effective 1/1/2014.
8.321.4 NMAC, Non- Accredited Residential Treatment Center Services, filed 2/17/2012 - Repeal effective 1/1/2014
8.321.5 NMAC, Outpatients and Partial Hospitalization Services in Freestanding Psychiatric Hospitals, filed 1/5/2012 - Repealed effective 1/1/2014.
8.322.2 NMAC, Treatment Foster Care, filed 2/17/2012 - Repealed effective 1/1/2014.
8.322.3 NMAC, Behavioral Management Skills Development Services, filed 10/12/2005 - Repealed effective 1/1/2014.
8.322.4 NMAC, Day Treatment, filed 10/12/2005 - Repealed effective 1/1/2014.
8.322.5 NMAC, Treatment Foster Care II, filed 2/17/2012 - Repealed effective 1/1/2014.
8.322.6 NMAC, Multi-Systemic Therapy, filed 11/16/2007 - Repealed effective 1/1/2014.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 12/17/2013, Repealed effective 8/10/2021.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 12/3/2019, Repealed effective 8/10/2021.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 7/22/2021, Repealed effective 12/1/2024.

Other History:

8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 12/17/2013 was replaced by 8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement effective 8/10/2021.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 12/3/2019 was replaced by 8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement effective 8/10/2021.
8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement filed 7/22/2021 was replaced by 8.321.2 NMAC, Specialized Behavioral Health Provider Enrollment and Reimbursement effective 12/1/2024.

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.1 NMAC, Sections 7, 8, 9 and 10, effective 12/10/2024.

6.50.1.7 DEFINITIONS: The definitions listed below apply to all [~~rule~~] rules pertaining to the authority, the authority's risk-related and employee-benefit coverages and any rules issued by the authority concerning risk or loss prevention, except where other rules contain more specific definitions of the same term or additional terms.

A. "Abatement" means the elimination of a recognized risk-related hazard as the result of a recommendation by a [~~loss prevention representative~~] risk management consultant or by the authority.

B. "Affidavit of domestic partnership" means a sworn, written statement, in a form, verified by the employer and approved by the authority, by which both members of a domestic partnership affirm, solely for the purpose of obtaining employee domestic partner benefits through the authority, that:

(1) the partners are in an exclusive and committed relationship for the benefit of each other, and the relationship is the same as, or similar to, a marriage relationship in the state of New Mexico;

(2) the partners share a primary residence and have done so for 12 or more consecutive months;

(3) the partners are jointly responsible for each other's common welfare and share financial obligations;

(4) neither partner is married or a member of another domestic partnership;

(5) both partners are at least 18 years of age;

(6) both partners are legally competent to sign an affidavit of domestic partnership; and

(7) the partners are not related by blood to a degree of closeness that would prevent them from being married to each other in the state of New Mexico.

C. "Affidavit terminating domestic partnership" means a sworn, written statement, in a form approved by the authority, by which an employee notifies the authority that domestic partner benefits should be terminated because the employee's domestic partnership relationship is terminated.

D. "Authority" means the New Mexico public school insurance authority.

E. "Board" means the board of directors of the authority.

F. "Change of status" means the change of status of an eligible employee or eligible dependent by:

(1) death;

(2) divorce or annulment;

(3) loss of employment;

(4) loss of group or individual health insurance coverage through no fault of the person having the insurance coverage;

(5) birth;

(6) adoption or child placement order in anticipation of adoption;

(7) legal guardianship;

(8) marriage;

(9) incapacity of a child;

(10) establishment or termination through affidavit of domestic partnership or affidavit terminating domestic partnership; or

(11) fulfilling the actively at work requirement and minimum qualifying number of hours through promotion to a new job classification with a salary increase or acceptance of a full-time position with a salary increase with the same participating entity.

G. "Charter school" means a school organized as a charter school pursuant to the provisions of the 1999 Charter Schools Act, Section 22-8B-1 et seq., NMSA 1978.

H. "Contract period" when applied to employee benefit or risk-related coverages means the established period of time over which the authority provides insurance to participating entities. The contract period shall be specified by the board as part of a memorandum of coverage, a group benefits policy, or administrative services agreement. The contract period may be different for different offerings, policies, or agreements.

I. "Costs" means the direct and indirect monetary and economic costs of insurance.

J. "Coverage" means insurance protection offered or provided by the authority to persons or entities entitled to participate in the authority's offerings.

K. "Critical hazard" means any risk-related exposure, hazardous condition, or other circumstance having an above average potential for immediate occurrence, but which is not immediately life threatening. A critical hazard is of less severity than an imminent hazard.

L. "Deductible" means the dollar amount [~~which~~] that will be deducted from any payments made to or on behalf of a participating entity or employee or covered individual.

M. "Domestic partner" means an unrelated person living with and sharing a common domestic life with an employee of an entity offering domestic partner benefits, where the employee and the partner submit a properly executed affidavit of domestic partnership and where the employee and the partner presently:

(1) are in an exclusive and committed relationship for the benefit of each other, and the relationship is the same as, or similar to, a marriage relationship in the state of New Mexico;

(2) share a primary residence and have done so for 12 or more consecutive months;

(3) are jointly responsible for each other's common welfare and share financial obligations; and

(4) are not married or in another domestic partnership.

N. "Domestic partner benefits" means dependent insurance coverage for a domestic partner offered to an employee as a benefit of employment pursuant to a written petition adopted by a member's governing body that:

(1) states that the member's governing body has voted in an open, public meeting to offer domestic partner benefits to its employees;

(2) sets forth the percentage contribution, if any, the member will make toward an employee's premium for domestic partner coverage;

(3) describes any evidence (documentation or other) the member will require in support of an affidavit of domestic partnership; and

(4) is received by the authority at its offices before the effective date the coverage is to begin.

O. "Due process reimbursement" means the reimbursement of a school district's or charter school's expenses as defined in Section 22-29-3 NMSA 1978 which are incurred as a result of a due process hearing as required pursuant to Section 22-29-12 NMSA 1978.

P. "Eligible dependent" means a person obtaining health care coverage from the authority based upon that person's relationship to the eligible employee as follows:

(1) a person whose marriage to the eligible employee is [~~evinced~~] evidenced by a marriage certificate or who

has a legally established common-law marriage in a state [~~which~~] that recognizes common-law marriages and then moves to New Mexico;

(2) a person who is the domestic partner of an eligible employee, employed by an entity offering domestic partner benefits;

(3) a child under the age of 26 who is either:

(a) a natural child;

(b) a legally adopted child pursuant to the Adoption Act, Section 32A-5-1, et. seq. NMSA 1978 or [~~otherwise~~] by adoptive placement order, court order or decree;

(c) a [~~step child~~] stepchild who is primarily dependent on the eligible employee for maintenance and support;

(d) a natural or legally adopted child of the eligible employee's domestic partner or a child placed in the domestic partner's household as part of an adoptive placement, legal guardianship, or by court order [~~(excluding foster children)~~] and who is living in the same household and is primarily dependent on the eligible employee for maintenance and support;

(e) a child for whom the eligible employee is the legal guardian and who is primarily dependent on the eligible employee for maintenance and support, so long as evidence of the legal guardianship is evidenced in a court order or decree (notarized documents, powers of attorney, or [~~kinship documents~~] conservatorships are not accepted as evidence);

(f) a foster child living in the same household as a result of placement by a state licensed placement agency, so long as the foster home is licensed pursuant to Section 40-7A-1, et. seq. NMSA, 1978;

(g) a child living in the same household after a petition for adoption of that child has been filed pursuant to the Adoption Act, Section 32A-5-1 et. seq. NMSA 1978 or a pre-placement study is pending for purposes of adoption of the child pursuant to Section 32A-5-1 et. seq. NMSA 1978; or

(h) a dependent child pursuant to a qualified medical support order;

(4) a dependent child over 26 who is wholly dependent on the eligible employee for maintenance and support and who is incapable of self-sustaining employment by reason of mental [~~retardation or physical handicap~~] or physical disability, provided that proof of incapacity and dependency, with proper medical certification, must be provided within 31 days before the child reaches 26 years of age; any child who becomes so incapacitated while covered shall be allowed to continue coverage thereafter during the period of incapacity, and such times thereafter as may be authorized by the board;

(5) no provision in Paragraphs (1) through (4) of Subsection P of 6.50.1.7 NMAC shall result in eligibility of any person adopted by an eligible member pursuant to the adult adoption provisions of Section 40-14-5 NMSA 1978;

(6) no provision in Paragraphs (1) through (4) of Subsection P of 6.50.1.7 NMAC shall result in eligibility of any person who has met the requirements of any such paragraph for the primary purpose of obtaining eligibility under this chapter; any denial of eligibility under this subsection may be submitted for dispute resolution to the director of the authority pursuant to Subsection F of 6.50.10.13 NMAC, and the director's decision may be appealed by following the procedures specified in 6.50.16 NMAC, Administrative Appeal of Authority Coverage Determinations.

Q. "Eligible participating entity board member, entity governing body member or authority board member" means an active participating entity board member, entity governing body member or authority board member whose entity is currently participating in the authority employee benefits coverages or who is eligible as an active authority board member or as an eligible retiree (Subsection R of 6.50.1.7 NMAC).

R. "Eligible retiree" means:

(1) a closed class: a "non-salaried eligible participating entity governing authority member" who is a former board member, who has served without salary as a member of the governing body of an employer eligible to participate in the benefits coverages of the authority, and is certified to be such by the director of the authority and has continuously maintained group health insurance coverage through that member's governing body; "eligible retiree" also includes former members of the authority board who has continuously maintained authority group health insurance; with respect to authority and participating entity board members who begin service after January 1, 1997, may participate in the benefits coverages; coverage will end at the request of the member, death or for non-payment;

[~~**(2)** a "grandfathered retired employee" or "grandfathered retired employee dependent" defined as a retired employee or the dependent of the retired employee who meets all applicable retirement rules of the Educational Retirement Act and educational retirement board but does not receive an Educational Retirement Act pension, and who has been allowed to continue authority coverages prior to the enactment of the Retiree Health Care Authority Act or by agreement between a new member school district or other educational entity;~~

~~**(3)**~~] **(2)** a "retired employee" who is drawing an Educational Retirement Act pension or with respect to a retired authority employee, a Public Employee Retirement Act pension, and desires to participate in the authority's additional life coverage.

S. "Eligible employee" means an employee of an employer eligible to participate in the benefits coverages of the authority including eligible participating entity board members, entity governing body members and authority board members (Subsection Q of 6.50.1.7 NMAC), full-time employees (Subsection X of 6.50.1.7 NMAC), or eligible part-time employees (Subsection T of 6.50.1.7 NMAC).

T. "Eligible part-time employee" means a person employed by, paid by, and working for a participating entity less than 20 hours but more than 15 hours per week during the academic school term and is determined to be eligible for participation in authority employee benefits coverages by an annual resolution which, prior to May 1 of the previous year, is adopted by the participating entity governing body and approved by the authority board.

U. "Employee benefits minimum standards" means the minimum coverages, minimum limits and other factors as specified in authority rules for which insurance is offered.

V. "Established enrollment period" means the period of time and the dates for which an enrollment period is authorized by the authority. [~~The established enrollment period shall be determined by the board on separate lines of employee benefit coverages as the authority board deems appropriate.~~]

W. "Financial interest" means an interest of ten percent or more in a business or exceeding $10,000.00 in any business. For a board member, official, employee, agent, consultant or attorney this means an interest held by the individual, [~~his or her~~] their spouse, [~~his or her~~] their domestic partner, or [~~his or her~~] their minor children.

X. "Full-time employee" means a person employed by, paid by and working for the participating entity 20 hours or more per week during the academic school term or terms. A full-time employee includes participating entity board members, entity governing body members and authority board members as defined in Subsections SS and TT of 6.50.1.7 NMAC.

Y. "Fund" means the authority account or accounts in which the money received by the authority is held.

Z. "Governing body" means the elected board or other governing body that oversees and makes the policy decisions for a school district, charter school or other educational entity. (See also Subsection UU of 6.50.1.7 NMAC)

AA. "Imminent hazard" means those conditions or practices which exist requiring suspension of activities or operations so as to avoid an occurrence which could reasonably be expected to result in death or serious physical harm immediately or before the imminence of such danger can be eliminated through the recommended abatement.

BB. "Ineligible dependents" means:

(1) common law relationships of the same or opposite sex which are not recognized by New Mexico law unless domestic partner benefits are offered by the employee's entity;

[~~**(2)** dependents while in active military service;~~

~~**(3)**~~] **(2)** parents, aunts, uncles, brothers and sisters of the eligible employee;

[~~**(4)**~~] **(3)** grandchildren left in the care of an eligible employee without evidence of legal guardianship; or

[~~**(5)**~~] **(4)** any other person not specifically referred to as eligible.

CC. "Insider information" means information regarding the authority which is confidential under law or practice or which is not generally available outside the circle of those who regularly serve the authority as board members, officials, employees, agents, consultants or attorneys.

DD. "Insurance" means basic insurance, excess insurance, re-insurance, retrospectively rated insurance, self-insurance, self-insured retention and all other mechanisms to provide protection from risks assumed by the authority.

EE. "Insurance policy" means one or more basic insurance policies, excess insurance policies, reinsurance policies, retrospectively rated insurance policies, or other insurance policies sought or obtained by the authority from one or more insurance companies to provide contractual protection against one or more risks or perils or which provide health related services.

FF. "Line" means insurance protection which protects against a specific category or set of perils.

GG. "Loss prevention" means a system for identification and reduction of risk-related exposures, hazardous conditions or other circumstances likely to produce a loss.

HH. "[~~**Loss prevention representative**~~] **Risk management consultant (RMC)"** means the employee of the contracted risk-related agency or the authority charged with the responsibility of providing loss prevention services to the authority.

II. "Memorandum of coverage" means the document which lists all terms and conditions of risk-related coverages.

JJ. "Member" and "members" means all public school districts and charter schools mandated by the New Mexico Public School Insurance Authority Act, Section 22-29-9 et seq. NMSA 1978 to be members of the authority and all other educational entities voluntarily participating in the authority.

[~~**KK. "Minimum participation level"** means that level of required participation by eligible employees of a participating entity in the authority employee benefits coverages for the particular line of coverage. The percentage level of required participation may vary from one line of coverage to another line of coverage as determined by the board from time to time.~~

~~**LL. "Native American employees"** or **"native American**~~

~~**dependents"** are those persons on the membership rolls of any recognized Indian tribe, nation, or pueblo.~~

~~**MM**~~] **KK.**

"Occurrence" means continuous and repeated exposures to substantially the same general harmful conditions, accidents or events. All such exposures to substantially the same general condition shall be considered as arising from one occurrence.

[~~**NN**~~] **LL.** **"Offering"** refers to any single line offering, multi-option or package offering made available by the authority.

[~~**OO**~~] **MM.** **"Other educational entity"** means an educational entity as defined in Section 22-29-3, NMSA 1978 which is an authority member pursuant to Section 22-29-9E NMSA 1978.

[~~**PP**~~] **NN.** **"Package offering"** means combining together of two or more lines of risk-related insurance.

[~~**QQ**~~] **OO.**

"Participant" means a person receiving employee benefit coverage from the authority.

[~~**RR**~~] **PP.**

"Participating entity" means a school district, charter school or other educational entity receiving authority coverage.

[~~**SS**~~] **QQ.**

"Participating authority board member" means a person that is appointed to serve and is serving as a member of the authority board.

[~~**TT**~~] **RR.**

"Participating entity board member" or **"participating entity governing body member"** means a person that is elected or appointed to serve and is serving as a member of the governing board of a participating entity.

[~~**UU**~~] **SS.**

"Participating entity governing board" means the elected or appointed board or other governing body that oversees and makes the policy decisions for the school board, charter school or educational entity.

[~~**VV**~~] **TT.** **"Part-time employee"** means a person employed by, paid by and working for the participating entity less than 20 hours per week during the academic school term [~~or terms~~] or as determined by the employer.

[~~**WW**~~] **UU.** **"Public official"** means a person serving the authority as board member, official, employee, agent, consultant or attorney or as a member of an ad hoc or standing authority advisory committee.

[~~**XX**~~] **VV.**

"Recommendation" means a method or means of risk-related corrective action suggested to a participating entity to eliminate a designated hazard.

[~~**YY**~~] **WW.** **"Request for waiver"** means a request for waiver of participation.

[~~**ZZ**~~] **XX.** **"Review board"** means the risk-related loss prevention review board. In the event a risk-related loss prevention review board is not designated by the authority board, "review board" means the risk advisory committee of the board.

[~~**AAA**~~] **YY.** **"RFP"** means a request for proposals and consists of all papers including those attached to or incorporated by reference in a document used to solicit proposals for insurance policies or professional services.

[~~**BBB**~~] **ZZ.** **"Risk-related coverage"** means any coverage required under the Tort Claims Act, Section 4-41-1 et seq. NMSA 1978, or any other state mandate and any coverage provided at the authority's discretion.

[~~**CCC**~~] **AAA.** **"School district"** means any school district as defined in Section 22-29-3 NMSA 1978.

[~~**DDD**~~] **BBB.** **"Self-insured retention"** means that dollar amount from the first dollar of loss up to a maximum amount for which the risk of loss is retained as determined by the authority.

[~~**EEE**~~] **CCC.** **"Special events"** mean events that permit enrollment in employee-benefits coverages.

[~~**FFF**~~] **DDD.** **"State"** means the state of New Mexico.

[~~**GGG**~~] **EEE.** **"Waiver"** or **"waiver of participation"** means a written document issued by the authority to a school district or charter school excusing the school district or charter school from participation in an authority offering. A school district or charter school may submit a request for waiver of participation for each authority offering.

[6.50.1.7 NMAC - Rp, 6.50.1.7 NMAC, 9/1/2014; A, 12/10/2024]

6.50.1.8 COMMUNITY RELATIONS:

A. The board recognizes its responsibility to the public to provide information concerning all of its actions, its policies, and details of its educational and business operations. In recognition of this responsibility the board shall:

(1) open to the public all regular, special and emergency meetings of the authority's board of directors and board standing committees [~~and board ad hoc committees~~] with notice consistent with the Open Meetings Act, Section 10-15-1 et seq. NMSA 1978 and the resolution adopted by the board governing open meetings;

(2) adopt an annual budget at an open public meeting announced publicly in advance;

(3) provide annual reports of financial and operational activities to members and to the public upon payment of reasonable copying costs pursuant to the Inspection of Public Records Act, Section 14-2-1 et seq. NMSA 1978; and

(4) inform the public of authority matters through appropriate public news media, authority publications and an informational website.

B. The board recognizes that constructive study, discussion and active participation by citizens are necessary to promote the best possible programs of insurance in the community. The board shall do the following to encourage this participation.

(1) The board

shall invite participating entities to assist individually or in groups in matters of concern to the authority.

(2) The board shall select, from time to time, committees to serve as study groups to investigate concerns. Each committee shall be appointed by the board for a specific purpose and, after final reports have been completed, shall be dissolved. The function of such committees shall not extend beyond that of study and recommendation as the board shall not delegate its responsibility for discretionary action to any such group.

(3) The board shall encourage participation by school districts, charter schools, other educational entities, employees of educational institutions and interested citizens.

C. Members of the public are entitled to inspect and make copies of public documents of the authority in accordance with the Inspection of Public Records Act, Section 14-2-1 et seq. NMSA 1978. [6.50.1.8 NMAC - Rp, 6.50.1.8 NMAC, 9/1/2014; A, 12/10/2024]

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.

A. The authority's board shall be composed of a total of 11 members as provided by Section 22-29-5 NMSA 1978. Solely for the purposes of board membership under Section 22-29-5 NMSA 1978, the term "participating educational entities" as used in that section is defined to mean those educational entities that participate in the authority employee benefits coverages or risk-related coverages or both.

B. Membership on the board shall be for a term not to exceed three years pursuant to Section 22-29-5, NMSA 1978. Members shall serve on the board at the pleasure of the party by which [~~he has~~] they have been appointed and may be removed by the appointing party for any reason at any time.

C. Alternate representatives to the board shall not be allowed. Voting by proxy also shall not be allowed.

D. A board member shall assume office at the time the appointing entity files written notification of the appointment of the board member at the office of the authority. The written notice shall contain the name, title, business address and business and home telephone number of the board member. A board member shall serve until written notification of a change is filed with the authority or until the three-year term is expired. There is no limitation as to the number of terms a board member may serve.

E. The board shall hold an annual meeting [~~each August~~] no later than the end of August. At the option of the board the annual meeting may be scheduled to coincide with [~~the~~] a regular [~~August~~] meeting of the board.

F. The officers of the board shall be elected from the board membership. The officers shall consist of a president, a vice-president, and a secretary, [~~who shall be elected at the annual meeting of the board~~] and shall serve for a period of one year. An officer may be reelected to the same position or elected to fill another position as an officer of the board.

G. If an officer vacates [~~his~~] their position on the board, the next lower officer shall automatically assume the duties of the higher officer. For example, if the presidency becomes vacant, the vice-president shall automatically assume the title and duties of president and the secretary shall automatically assume the title and duties of vice-president. After due notice, a new secretary will be elected by the board. In the alternative to the automatic progression to higher office, the board may call a special meeting for the purpose of conducting an election of officers in the event of any vacancy in a board office. Each of the new officers, however selected, shall serve until election of officers at the next annual meeting.

H. The regular meetings of the board shall normally be held monthly, in a place to be determined [~~from time to time~~] as necessary by the board. The date of any regular meeting may be changed by a majority vote of a quorum of the board. The president or vice-president may cancel a regularly scheduled meeting of the board by giving notice of the cancellation in advance of any regularly scheduled meeting.

I. Robert's Rules of Order are adopted by the board and shall be used for the conduct of all meetings to be held by the authority. Robert's Rules of Order shall be binding in all cases where they are not inconsistent with New Mexico statutes and rules adopted by the authority.

J. Meetings of the board other than regular meetings shall be called according to the following procedures.

(1) A special meeting of the board is a meeting other than a regular or emergency meeting and may be called by the president, vice-president or any three board members for the specific purposes specified in the call. The call shall be made in accordance with the Open Meetings Act requirements, Section 10-15-1 et seq. NMSA 1978, and board resolutions.

(2) An emergency meeting of the board is a meeting other than a regular or special meeting and may be called by the president, vice-president, or any two members of the board to consider a sudden or unexpected set of circumstances affecting the authority for which time is of the essence. The call shall be made in accordance with the Open Meetings Act requirements, Section 10-15-1 et seq. NMSA 1978, and board resolutions.

K. A majority of all of the board members shall constitute a quorum for conducting the affairs of the authority. The president of the board shall be entitled to debate any issue and vote on any issue in the same manner as other members

of the board. The president shall be considered to be a member of the board for purposes of a quorum. All matters will be determined by voice vote. Any member of the board may request a roll call vote on any issue. In the event of a roll call, it shall be in alphabetical order, by last name, with the president voting last.

L. The board shall be addressed according to the following procedures.

(1) An individual may speak on any item that appears on the adopted agenda, before a final vote is taken, by notifying and subsequently being recognized by the president or vice-president. The president or vice-president may, at [~~his~~] their discretion, limit the time any individual or entity is allotted to make a presentation and the president or vice-president may, [~~in his~~] at their discretion, limit the time allotted for any subject.

(2) A person with a matter to present to the board shall submit the request in writing with appropriate supporting materials [~~four~~] six working business days in advance of a regularly scheduled meeting, 24 hours in advance of a special meeting and [~~three~~] five hours in advance of an emergency meeting.

M. The board retains and reserves unto itself all powers, rights, authority, duties and responsibilities conferred upon and vested in it by the constitution of the state of New Mexico and statutes, including those prescribed by Sections 22-29-1 et. seq. NMSA 1978, and such other power and authority as may be conferred upon the board [~~from time to time~~] as necessary. In the execution of those powers and duties specifically provided by law, the board has the following general power and authority to:

(1) exercise general control and management of the authority, third party administrators, consultants retained by the authority and other agents, servants and employees;

(2) establish such programs, and provide such services as it deems necessary for the proper and efficient operation of the authority and the good of the participating entities;

(3) exercise control and management of all authority assets and use such assets to promote authority business in such ways as the board deems necessary and proper in accordance with law;

(4) make and adopt or amend rules and regulations for governance of the authority by a majority of the board membership;

(5) make and adopt or amend substantive rules and regulations by a majority vote of the board membership;

(6) repeal a substantive rule of the authority by a majority vote of the board membership, but the board has no power to suspend any substantive rule except by a two-thirds vote of the membership of the board;

(7) make provisions for interpreting the authority's programs for dissemination to the public and to seek the opinion and advice of the participating entities concerning the authority's insurance programs;

(8) work in a cooperative manner with interested citizens in a continuous effort to improve the authority's programs;

(9) appoint advisory committees, including a risk advisory committee and an employee benefits advisory committee, which are permanent standing committees of the board, as well as ad hoc advisory committees as needed;

(10) establish an executive committee, a permanent standing committee of the board, which shall be made up of the president, vice-president and secretary of the board and which shall serve as the agenda committee; and

(11) hire an executive director and to delegate to the executive director the [~~day to day~~] day-to-day activities of the authority pursuant to board policy as developed in its open meetings.

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.

O. An ad hoc advisory committee shall be established for a specific purpose or goal and shall be established for a stated period of time.

P. Members of advisory committees, including members of the loss prevention review board, shall be appointed by the president of the board with the advice and consent of the board and shall serve at the pleasure of the board. [~~Advisory committees shall provide notice of meetings as required by the Open Meetings Act, Section 10-15-1 et seq. NMSA 1978, and these rules.~~] Minutes in compliance with Subsection R of 6.50.1.9 NMAC shall be kept by the [~~chairman or his designee~~] authority. Advisory committee minutes shall be considered acted upon when the board acts on the advisory committee report.

Q. The authority shall pay per diem and mileage consistent with the Per Diem and Mileage Act, Section 10-8-1 et seq. NMSA 1978, as amended, and the applicable department of finance and administration rules. The per diem and mileage payments shall be limited to the following situations.

(1) Authority employees are entitled to receive per diem and mileage for travel incurred in the normal course and scope of their employment; provided however, that no employee shall be entitled to receive per diem and mileage for travel outside of the state without obtaining the board's prior approval for the travel.

(2) Authority board members are entitled to

receive per diem and mileage for travel incurred for attending all regular, special and emergency board meetings, or any standing or ad hoc committee meetings of the board called pursuant to the Open Meetings Act, Section10-15-1 et seq. NMSA 1978 and the authority's open meetings resolution. In addition, the executive committee serving as the authority board agenda committee is entitled to receive per diem and mileage for travel incurred as necessary to conduct the business of the board. Authority board members shall not be entitled to receive per diem and mileage for any other travel, inside or outside of the state, without obtaining prior approval of the board.

(3) Authority advisory committee members named by the board to serve on advisory committees are entitled to receive per diem and mileage for travel incurred for attending authority advisory committee meetings which has been scheduled in writing by the board or by the executive director. Authority advisory committee members shall not be entitled to receive per diem and mileage for any other travel, inside or outside of the state, without obtaining prior approval of the board.

R. Minutes of the board.

(1) The authority shall keep written minutes of all its open meetings. The minutes shall include as a minimum the date, time and place of the meeting, the names of members in attendance and those absent, the substance of the proposals considered, if any, and a record, where appropriate, of any decisions and votes taken which show how each member voted. All minutes of meetings shall be open to public inspection at reasonable times. Draft minutes shall be prepared within 10 working days after the meeting. Minutes shall not become official until approved by the board. The minutes shall be kept on file as the permanent official record of the authority.

(2) It is the practice of the authority staff (but not a requirement by the authority board) that board meetings are [~~tape~~] recorded. [~~The board secretary~~] Authority staff shall make notes of board meetings sufficient to reflect the information required in Paragraph (1) of Subsection R of 6.50.1.9 NMAC, and the tape recording shall be available to the secretary, any board member or member of the public for review with regard to the accuracy of draft minutes. However, 30 days after minutes have been adopted by the board, [~~the board secretary shall recycle the tapes by erasure and make them available for re-use~~] authority staff may dispose of recordings. [6.50.1.9 NMAC - Rp, 6.50.1.9 NMAC, 9/1/2014; A, 10/1/2015; A, 12/10/2024]

6.50.1.10 CODE OF ETHICS:

A. Registration and disclosure duties of public officials.

(1) Upon becoming a public official, a person shall provide [~~registration information to the authority~~] a financial disclosure to the secretary of state and a copy to the authority office as listed below. This information shall be updated [~~every April~~] by January 31 at midnight each year thereafter as long as the filer holds the same position and shall be available to the public at all times:

(a) name;

(b) address and telephone number;

(c) professional, occupational or business licenses;

(d) membership on boards of directors of corporations, public or private associations or organizations; and

[~~**(e)**~~] the nature, but not the extent or amount, of [~~his~~] their financial interests as defined in Subsection X of 6.50.1.7 NMAC within one month of becoming a public official.

(2) A public official who has a financial interest which may be affected by an official act of the authority, ad hoc or advisory committee shall declare such interest prior to discussion, voting, advising or taking any other action and that declaration shall be entered in the official minutes of the authority. A public official shall abstain from voting, advising or taking any other action including discussion on that issue if the decision, in [~~his~~] their opinion, may affect [~~his~~] their financial interest in a manner different from its effect on the general public.

B. No public official shall request or receive a gift or loan for personal use or for the use of others from any person involved in a business transaction with the authority with the following exceptions:

(1) an occasional non-pecuniary gift of insignificant value;

(2) an award publicly presented in recognition of public service;

(3) a commercially reasonable loan made in the ordinary course of business by an institution authorized by the laws of the state to engage in the business of making loans; or

(4) a political campaign contribution, provided that such gift or loan is properly reported and actually used in a political campaign.

C. No public official shall personally represent private interests before the authority board or any ad hoc or standing committee.

D. No public official shall use or disclose insider information regarding the authority for [~~his~~] their own or other's private purposes.

E. No public official shall use authority services, personnel or equipment for personal benefit, convenience or profit, except when such use is generally available to the public and when in accordance with policies of the authority board.

F. No public official shall acquire or negotiate to acquire a financial interest at a time when the official believes or has reason to believe that it will be substantially or directly affected by [~~his~~] their official acts.

G. No public official shall enter into a contract or

transaction with the authority or its public officials, unless the contract or transaction is made public by filing notice with the authority board.

H. No public official shall vote or otherwise participate in the negotiation or the making of any authority contract with any business or entity in which [~~he has~~] they have a direct financial interest.

I. No public official shall seek to be awarded a contract where such public official has participated in the process of preparation of the bid or request for proposals.

J. Any contract, approval, sale or purchase entered into or official action taken by a public official in violation of 6.50.1.10 NMAC may be voided by action of the authority board.

K. It is a violation of 6.50.1.10 NMAC for any public official knowingly, willfully or intentionally to conceal or fail to disclose any financial interest required to be disclosed by 6.50.1.10 NMAC or violate any of its provisions.

L. Any person may make a sworn, written complaint to the authority board of a violation by a public official of 6.50.1.10 NMAC. Such complaint shall be filed with the authority executive director or if it is a complaint against the executive director, then with the authority board. The complaint shall state the specific provision of 6.50.1.10 NMAC which has allegedly been violated and the facts which the complainant believes support the complaint. Within 15 days of receiving the complaint, the authority board in executive session shall appoint a hearing officer to review the complaint for probable cause. The hearing officer shall receive the written complaint and notify the person complained against of the charge. Persons complained against shall have the opportunity to submit documents to the hearing officer for [~~his~~] review in determining probable cause. Within 15 days of undertaking the inquiry to determine probable cause, the hearing officer shall report [~~his~~] findings to the authority board. In the event the hearing officer rejects a complaint as lacking in probable cause, [~~he~~] they shall provide a written statement of reasons for [~~his~~] the rejection to the authority board and the complainant. Upon a finding of probable cause, within 30 days the hearing officer shall conduct an open hearing in accordance with due process of law. Within a time after the hearing, as specified by the authority board, the hearing officer shall report [~~his~~] the findings and recommendations to the authority board for appropriate action based on those findings and recommendations. If the complaint is found to be frivolous, the authority board may assess the complainant the costs of the hearing officer's fees. Upon recommendation of the hearing officer, the authority board may issue a public reprimand to the public official; remove or suspend [~~him~~] from [~~his~~] office, employment or contract and refer complaints against public officials to the appropriate law enforcement agency for investigation and prosecution.

M. The executive director and the authority board shall maintain the confidentiality of the complaint and instruct the complainant that [~~he is~~] they are also required to keep the complaint confidential pursuant to Subsection L of 6.50.1.10 NMAC. Except for the hearing, the proceedings shall be kept confidential by all parties concerned, unless the accused public official requests that the process be open at any stage.

N. A separate hearing officer shall be appointed by the authority board for each complaint. The hearing officer may be an authority board member, agent or employee of the authority or another person. The complainant and the person complained against have the right to one disqualification of a designated hearing officer.

[6.50.1.10 NMAC - Rp, 6.50.1.10 NMAC, 9/1/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.2 NMAC, Sections 14 and 26, effective 12/10/2024.

6.50.2.14 PROCUREMENTS AFTER PROTEST:

A. In the event of a timely protest, as defined in 6.50.2.12 and 6.50.2.13 NMAC, the executive director shall not proceed further with the procurement unless [~~he~~] the director makes a written determination that it is necessary to go forward with the award of the contract to protect substantial interests of the authority. Such written determination shall set forth the basis for the determination.

B. In no circumstance will a procurement be halted after a contract has been awarded merely because a protest has been filed.

C. The point in time in which a contract is awarded is that point at which a legally enforceable contract is created, unless the context clearly requires a different meaning.

[6.50.2.14 NMAC - Rp, 6 NMAC 50.2.14, 09/01/2014; A, 12/10/2024]

6.50.2.26 VOUCHER APPROVAL -- PROFESSIONAL SERVICES

A. No voucher for payment of professional services will be approved by the board or its [~~third-party~~] third-party administrators, other than a payroll voucher or travel voucher, unless the contract and any amendments to the contract have been approved where required by these rules. [~~All vouchers must contain the contract identification number.~~]

B. The board or its [~~third party~~] third-party administrators shall not approve any voucher for the payment of professional services unless the voucher certifies that the services have been rendered.

[6.50.2.26 NMAC - Rp, 6 NMAC 50.2.26, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.3 NMAC, Section 9, effective 12/10/2024.

6.50.3.9 AUTHORIZATION TO OFFER RISK RELATED COVERAGES: The authority is authorized to offer risk-related coverages to all school districts, [~~and~~] charter schools, and other educational entities. The authority may offer risk-related coverages to individual other educational entities by special agreement.

[6.50.3.9 NMAC - Rp, 6 NMAC 50.3.9, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.4 NMAC, Sections 8, 9 and 10, effective 12/10/2024.

6.50.4.8 PROCEDURE FOR JOINING THE AUTHORITY BY OTHER EDUCATIONAL ENTITIES:

A. Other educational entities who desire to join the authority shall provide the following to the authority:

(1) an up-to-date employee census including for all employees their age, gender and classification;

(2) a minimum of three years loss reports and claims experience for all lines of authority coverages the other educational entity wishes to participate in;

(3) submission of financial and benefit information which meets standards set by the board;

(4) a resolution of the governing body of the other educational entity stating that it is requesting authority membership and participation in the authority's offerings of [~~risk related~~] risk-related and employee benefits coverages and a statement that the other educational entity will abide by the Public School Insurance Authority Act, Section 22-29-1 et seq. NMSA 1978, and all authority rules and board policies and will keep in force all authority coverages for the duration of the then existing carrier agreements;

(5) an agreement in a form acceptable to the authority whereby the governing body of the other educational entity agrees that it will abide by and be bound by the Public School Insurance Authority Act, Section 22-29-1 et seq. NMSA 1978, and all other authority rules and board policies, including authority claims processing, settlement practices and the authority schedule for payment of premiums, late penalties and applicable interest, and will take, pay for and keep in force for the duration of the carrier agreements all applicable authority coverages; and

(6) payment of [~~an excess premium deposit equal to ten percent of the total annual~~] the total first year premiums, however, if the entity joins after July 1st, a prorated premium would be charged for the coverages selected [~~by the educational entity desiring to join the authority~~].

B. An other educational entity desiring to participate in only some of the authority's coverages shall apply for waivers as is required of school districts and charter schools pursuant to Subsections C and D of Section 22-29-9 NMSA 1978.

C. The authority may reject any application by any other educational entity with or without cause.

[6.50.4.8 NMAC - Rp, 6 NMAC 50.4.8, 09/01/2014; A, 12/10/2024]

6.50.4.9 PROCEDURE FOR EXITING THE AUTHORITY BY OTHER EDUCATIONAL ENTITIES:

A. Other educational entities can voluntarily exit the authority only at the expiration of the carrier agreements for the authority coverages they have selected.

B. Under no circumstances can other educational entities voluntarily exit the authority prior to having been a member for a minimum of three years.

C. An other educational entity desiring to exit the authority shall make a request to the board in writing stating the reasons why it desires to exit, with a provisional notice no later than one year prior to the expiration date and final notice will be provided no later than [~~90~~] 180 days prior to the expiration date of the carrier agreements for the authority coverages the other educational entity has selected. The board shall vote whether to accept the resignation of the other educational entity at its next regular meeting following receipt of the other educational entity's request to exit.

D. The board shall reevaluate annually other educational entities who violate authority rules, regulations or board policies, which have poor loss histories or which evidence clear signs of fiscal irresponsibility and the board may at its discretion terminate the other educational entity's membership in the authority upon 90-day notice.

[6.50.4.9 NMAC - Rp, 6 NMAC 50.4.9, 09/01/2014; A, 12/10/2024]

6.50.4.10 PENALTIES AGAINST OTHER EDUCATIONAL ENTITIES FOR FAILURE TO PARTICIPATE AFTER JOINING THE AUTHORITY:

A. Other educational entities may not drop any authority coverages prior to the expiration of carrier contracts. However, should a successor governing body of a participating other educational entity drop participation by refusing continued premium payments, the other educational entity shall be terminated from all coverages by the authority upon [~~30 day~~] 30-day notice and the following penalties shall be incurred.

(1) For risk-related coverages, the other educational entity shall forfeit to the authority any right to any reserves held on its behalf and shall pay to the authority the cost of any losses in excess of premium.

(2) For health and life employee benefits coverages, the other educational entity shall forfeit to the authority any right to any return premiums or reserves it may otherwise be entitled to. It shall pay to the authority any funds the authority has paid for or will pay for incurred claims related to the other educational entity in excess of premiums paid by the other educational entity as well as administrative expenses directly or indirectly related to claim payments including third party administrator costs and a reasonable percentage of the authority administrative costs.

B. If the other educational entity ceases to participate in authority coverages prior to expiration of the carrier contracts, it shall, in addition to any other penalties, pay to the authority any sums determined by the authority to be due in order to hold safe and harmless all other members of the authority from any adverse financial impact caused by its failure to participate.

[6.50.4.10 NMAC - Rp, 6 NMAC 50.4.10, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.5 NMAC, Section 8, effective 12/10/2024.

6.50.5.8 ESTABLISHMENT OF EMPLOYEE-BENEFIT AND RISK RELATED PREMIUMS:

A. The authority shall establish premiums necessary to protect the solvency of the fund considering all expenses, potential expenses and costs of the authority programs.

B. Whenever possible, the authority shall obtain loss experience for each line of coverage for each participating entity.

C. Whenever possible and economically feasible, the authority shall obtain professional actuarial advice to establish premium levels.

D. Whenever possible, the authority shall consider the loss experience of each particular participating entity as a primary factor in establishing the premiums for that entity. However, the authority shall also use other factors as necessary to protect the stability and solvency of the fund.

E. The authority shall also consider an appropriate premium increase of up to ten percent when presented with a member's untimely reporting of losses, in addition to a potential denial of a claim under the memorandums of coverages.

[~~E~~] **F.** Exposure information, which includes, but is not limited to, property values, vehicle counts, payroll, average daily attendance, budgets, new or hazardous exposures, is requested from each member typically in December of each year. This information is one of the factors used to allocate premiums among the members. The deadline for submission of this information to the authorized representative of the authority is the second Friday in January. The authorized representative shall have three to four weeks to review the data, ask and answer any questions and verify the information. The final deadline for the submission of all additional or amended exposure information by the members to the authorized representative is the second Friday in February. The board will have the final decision to approve or reject any late received exposure information. If the exposure information is not received by the deadlines described above, the board may, at its discretion, impose a ten percent penalty increase to that member's prior year's exposure information.

[~~F~~] **G.** If, at any time, the authority becomes aware that a member has under reported exposure information, an additional premium will be retroactively charged [~~at a rate to be determined by the board~~] back to the appropriate policy period.

[~~G~~] **H.** If, at any time, the authority becomes aware that a member over reports exposure information, the member will not receive any return of premiums paid. However, if there are extenuating circumstances, the member can request that the board waive the forfeiture of the return premium.

[6.50.5.8 NMAC - Rp, 6 NMAC 50.5.8, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.6 NMAC, Section 8, effective 12/10/2024.

6.50.6.8 COVERAGE NOTIFICATION: The authority will issue notification of coverage for each offering to each participating entity within 30 days of the inception of the coverage. The coverage notification may specify the types, limits, amounts and general terms of coverage to be provided to the participating entity. The notification shall state that a complete copy of the memorandum of coverage which governs risk-related and due process reimbursement coverages will be made available to all interested parties upon request. Each covered employee under employee benefits coverages shall [~~receive~~] have access to a summary plan description or insurance certificate. The terms of the insurance policy or memorandum of coverage, not the coverage notification or summary shall control in any dispute over coverage. Final determination of whether a claim is covered rests solely with the authority.

[6.50.6.8 NMAC - Rp, 6 NMAC 50.6.8, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.7 NMAC, Sections 8, 9, 12 and 14, effective 12/10/2024.

6.50.7.8 WAIVER OF PARTICIPATION: School districts and charter schools shall participate in and accept all authority offerings, unless the school district or charter school has applied for and been granted a waiver for an individual line of coverage by the authority board. If a waiver is granted for an individual line of coverage, the school district or charter school will not be provided any insurance protection or coverage by the authority for the perils covered by that individual line of coverage. The school district or charter school receiving the waiver accepts the obligation to obtain its own insurance protection for the perils covered by the individual line of coverage for which the waiver is granted. A school district or charter school that has been granted a waiver for an individual line of coverage shall be prohibited from participating in that individual line of coverage during the contract period, provided, however, the district or charter school may, if the authority contract period exceeds four years, again seek participation. [~~However, a school district or charter school may, if the authority contract period exceeds four years, again seek participation as if it were an other educational entity pursuant to 6.50.4.8 NMAC.~~]

[6.50.7.8 NMAC - Rp, 6 NMAC 50.7.8, 09/01/2014; A, 12/10/2024]

6.50.7.9 RESPONSIBILITIES OF SCHOOL DISTRICTS AND CHARTER SCHOOLS WHICH WAIVE PARTICIPATION IN AUTHORITY COVERAGES:

A. A school district or charter school may waive participation in either the risk related or group health insurance or both. Pursuant to Subsections C and D of Section 22-29-9, a school district or charter school must waive all risk-related or all group health insurance coverages or must petition for participation in the remaining coverages offered by the authority in that particular individual line of coverage.

B. Should a school district or charter school waive participation in an individual line of coverage, the school district or charter school shall be responsible for the following charges:

(1) For [~~risk-related~~] risk-related coverages, the school district or charter school shall forfeit to the authority any right to any return premiums or reserves and shall be responsible to pay to the authority on demand the cost of any prior losses in excess of premium and all the appropriate expenses of the authority in defending, settling and administering any such losses;

(2) For group health insurance, the school district or charter school shall forfeit to the authority any right to any return premium or reserves it may be entitled to. The school district or charter school shall also pay to the authority any funds paid for prior incurred claims of the school district or charter school in excess of premium paid by the school district or charter school and shall pay to the authority all the appropriate expenses of the authority in defending, settling and administering such claims.

C. Any school district or charter school waiving participation in an individual line of coverage shall pay to the authority any sums determined by the authority to be due in order to hold safe and harmless all other members of the authority from any adverse financial impact caused by the waiver of coverage. An accounting of funds and amounts owed by the school district or charter school shall not be due from the authority until two years after the waiver of participation has taken effect.

[6.50.7.9 NMAC - Rp, 6 NMAC 50.7.9, 09/01/2014; A, 12/10/2024]

6.50.7.12 APPROVAL OR DISAPPROVAL OF REQUEST FOR WAIVER OF PARTICIPATION: The authority board shall approve or disapprove a waiver of participation based on the documentation submitted by the school district or charter school. The board shall grant a waiver to a school district or charter school that shows evidence to the satisfaction of the board that:

A. In the event the waiver is with regard to group health insurance:

(1) that the school district or charter school has secured a valid written enforceable commitment from an insurer to provide group health insurance;

(2) that the coverage committed to the school district or charter school and the plan benefits for their employees is at least as beneficial as the plan being procured by the authority;

(3) that there are no more exclusions from coverage and the exclusions are not broader than those set out in the authority's request for proposals;

(4) that the deductibles, stop loss, out of pocket costs, etc., if any, result in no more costs to the employees than would occur pursuant to the authority's request for proposals;

(5) that any cost containment features not result in any higher costs or burdens on the employees than would result under the authority's request for proposals;

(6) that the prospective insurer of the school district or charter school have the same or greater rating as that required in the authority's request for proposals;

(7) that the notice of intent to request a waiver has been timely filed;

(8) that the request for waiver of participation has been timely filed;

(9) that all the data required to be included in the request for waiver of participation has been timely supplied;

(10) that the proposed insurer for the school district or charter school has satisfactorily demonstrated to the school district or charter school and

to the authority that the insurer in its proposal to the school district or charter school has adequately accounted in its rates for such items as school district or charter school experience, incurred but not reported losses, medical inflation trends and other relevant factors for the purpose of allowing the school district or charter school and the authority to determine the future viability of the plan, if rates are under-quoted at inception and whether the proposed insurer for the school district or charter school meets the minimum financial standards of the authority; and

(11) that the total group health insurance offering available in that school district or charter school compares favorably in all respects with the authority's request for proposals;

B. In the event the waiver is with regard to risk-related insurance:

(1) that the school district or charter school has secured a valid written enforceable commitment from an insurer to provide risk-related insurance;

(2) that there are no more exclusions from coverage and the exclusions are not broader than those in the authority's request for proposal;

(3) that the deductibles, [~~self insured~~] self-insured retention, etc., if any, are no higher or result in any more costs to the school district or charter school than would occur pursuant to the authority's request for proposal;

(4) that any cost containment features not result in any higher costs or burdens on the school district or charter school than would result under the authority's request for proposals;

(5) that the prospective insurers of the school district or charter school provide coverages as broad as is required in the authority's request for proposals;

(6) that the prospective insurers of the school district or charter school have the same or greater rating as required in the authority's request for proposals;

(7) that the notice of intent to request a waver has been timely filed;

(8) that the request for waiver of participation has been timely filed;

(9) that all the data required to be included in the request for waiver of participation has been included; and

(10) that the proposed insurer for the school district or charter school has satisfactorily demonstrated to the school district or charter school and to the authority that the insurer in its proposal to the school district or charter school has adequately accounted in its rates for such items as school district or charter school experience, incurred but not reported losses, the nature of existing coverage(claims made or occurrence) and other relevant factors for the purpose of allowing the school district or charter school and the authority to determine the future costs of coverages, to determine if rates are under-quoted at inception and whether the proposed insurer for the school district or charter school meets the minimum financial standards of the authority.

[6.50.7.12 NMAC - Rp, 6 NMAC 50.7.12, 09/01/2014; A, 12/10/2024]

6.50.7.14 AUTOMATIC WAIVER ALLOWED: School districts and charter schools are entitled to an automatic waiver for any line of authority coverage where the employee pays the full amount of the premium. If the school district or charter school desires insurance protection for a particular line of employee-pay-all coverage, the school district or charter school must affirmatively petition the authority for coverage. In granting the coverage the board shall first determine that the school district or charter school meets the minimum participation requirements as established by the board [~~from time to time~~] as necessary, that the school district or charter school will carry the coverage through the end of the contract period and that approval will not jeopardize the stability of the fund.

[6.50.7.14 NMAC - Rp, 6 NMAC 50.7.14, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.8 NMAC, Sections 8, 9, 10 and 12, effective 12/10/2024.

6.50.8.8 PREMIUM PAYMENT FOR [~~RISK-RELATED~~] RISK-RELATED AND DUE PROCESS REIMBURSEMENT COVERAGES: The authority shall invoice each member for risk-related and due process reimbursement coverages. Payment for risk-related and due process reimbursement coverages is due in full within 30 days after the billing date. Premium payments not received by the 10th day of the month following the due date shall be subject to an interest charge of one and one-half percent of the outstanding premium due for each month [~~they are~~] the member is overdue.

[6.50.8.8 NMAC - Rp, 6 NMAC 50.8.8, 09/01/2014; A, 12/10/2024]

6.50.8.9 PREMIUM PAYMENT FOR EMPLOYEE BENEFITS COVERAGES: The authority shall invoice each member [~~or the individual participant where direct billing is used, for the premiums~~] for the premiums for employee benefits coverages. Premium payments are due in full within 10 days after billing. Premiums are due no later than the 10th of the month for which coverage is intended. Premium payments not received by the 10th day of the month following the due date shall be subject to an interest charge of one and one-half percent of the outstanding premium due for each month the member is overdue.

[6.50.8.9 NMAC - N, 09/01/2014; A, 12/10/2024]

6.50.8.10 PREMIUM PAYMENT PLAN: Any member unable to make [~~its~~] their premium payment timely and in full must obtain a recommendation from the state secretary of education for any alternate payment schedule, which shall then be submitted to the board for approval. The board may accept or reject the secretary's recommendation.
[6.50.8.10 NMAC - Rp, 6 NMAC 50.8.9, 09/01/2014; A, 12/10/2024]

6.50.8.12 PROCEDURE FOR HANDLING DISPUTED PREMIUM BILLINGS: In the event any member or individual disputes the amount of the authority's billing, the member or individual shall pay the bill and then file a written statement requesting a refund of the disputed amount setting forth the amount and the reasons the member or individual believes the billing constitutes an overcharge. The request shall be filed within 60 days after the submission of the billing. Requests for refunds that are not timely filed shall be deemed to be rejected. The board shall place complaints regarding the amount of the authority's billings that are timely filed on the agenda of one of its meetings and give notice to the affected member or individual so the member or individual may attend and be heard.
[6.50.8.12 NMAC - Rp, 6 NMAC 50.8.11, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.9 NMAC, Sections 9, 10 and 11, effective 12/10/2024.

6.50.9.9 AUTHORITY'S LIMITATION OF LIABILITY FOR DUPLICATE OR OVERLAPPING BENEFITS PREMIUMS PAID: To the extent that the insurance coverage purchased by the member or individual participant duplicates or overlaps insurance coverage provided by the authority, the authority will not reduce or rebate any portion of its premium nor is the authority liable to the participating entity or to any individual participant for any premiums paid by the participating entity or the individual participant for duplicate or overlapping coverage.
[6.50.9.9 NMAC - Rp, 6 NMAC 50.9.9, 09/01/2014; A, 12/10/2024]

6.50.9.10 [~~RISK RELATED~~] RISK-RELATED OVERLAPPING INSURANCE COVERAGES: Where there is other insurance, no matter how acquired or provided to an insured, the authority shall follow the "guiding principles for overlapping insurance coverages " adopted by the association of casualty and surety companies, the inland marine underwriters association, the national automobile underwriters association, the national board of fire underwriters, the national bureau of casualty underwriters and the surety association of America to determine the obligations of the authority with respect to apportionment of losses with other insurers.
[6.50.9.10 NMAC - Rp, 6 NMAC 50.9.10, 09/01/2014; A, 12/10/2024]

6.50.9.11 EMPLOYEE BENEFITS COVERAGE/ COORDINATION OF BENEFITS RULES: Coordination of benefits ("COB") rules of the authority's medical and dental carrier shall prevail in any situation where a conflict exists with any other authority benefits carrier. In the event of a conflict among authority carriers addressed by COB rules, the COB rules of the carrier of coverages wherein the authority is at risk will prevail. In the event of a conflict between an authority carrier and a non-authority carrier addressed by the COB rules of the authority carrier, the authority carrier COB rules will prevail.
[6.50.9.11 NMAC - Rp, 6 NMAC 50.9.11, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.10 NMAC, Sections 7, 8, 9, 10, 11 and 13, effective 12/10/2024.

6.50.10.7 DEFINITIONS:

A. "Actively at work" for life and disability coverage, means performing the material duties of your own occupation at your employer's usual place of business. You will also meet the actively at work requirement if you were absent from active work because of a regularly scheduled day off, holiday or vacation day or if you were capable of active work on the day before the scheduled effective date of your insurance or increase in your insurance.

B. "Employee" means full time employee as defined in [~~Subsection Y~~] Subsection X of 6.50.1.7 NMAC. This definition applies to the rules related to employee benefits coverage contained in 6.50.10 NMAC only.
[6.50.10.7 NMAC - Rp, 6.50.10.7 NMAC, 09/01/2014; A, 12/10/2024]

6.50.10.8 REQUIREMENTS FOR ENROLLMENT OF FULL TIME EMPLOYEES:

A. An employee shall be enrolled pursuant to [~~his~~] their actual status at the time of enrollment. If a change in status of an employee occurs [~~he~~] they must notify the employer within 31 calendar days of the change and complete any enrollment documents required by the authority.

B. An employee may enroll [~~just himself~~] only themself. However, if the employee chooses to enroll one eligible dependent, the employee shall enroll all eligible dependents unless one or more eligible dependents have other coverage. If the dependent of an eligible employee participant is enrolled in another medical plan, the eligible employee participant may enroll in the authority's medical plan as a single and in the two-party

or family coverage for other lines. Evidence of the other coverage is required.

C. New eligible employees may enroll under the conditions set forth by the authority as follows:

(1) New eligible employees shall enroll within 31 calendar days of hire or within 31calendar days of being upgraded to eligible employee. Evidence of upgrade is required.

(2) A new participating entity governing body member or new participating authority board member shall enroll within 31 days of being sworn in to office.

(3) Coverage is effective on the first day of the month following the day the employee applies, provided the employee authorizes in writing that the premium is to be withheld from [~~his~~] their payroll check, subject to the actively-at-work provision, and for self-payers, the first day of the month following receipt of the premium by the authority.

(4) Where an employee is on a [~~12-month~~] payroll option, the employer shall deduct and remit from each payroll and shall remit the employer's contribution simultaneously.

(5) Where an employee seeks a transfer of benefits:

(a) the employee is covered until the end of the month for which coverage was paid at the school the employee is leaving;

(b) the employee shall enroll within 31 calendar days of hire at the school the employee is moving to; and

(c) participating entities shall coordinate the effective date to ensure duplicate premiums are not paid on behalf of the employee through the outgoing school as well as the incoming school.

(6) Eligible [~~employee~~] employees or dependents who involuntarily lose benefits coverage have a [~~31 day~~] 31-day window to enroll in the authority. Supporting documentation showing the reason for the involuntary loss of benefits coverage, the date benefits coverage was lost, who was covered and what types of benefits coverage was lost must be submitted within 31 days from the date of loss of coverage. The effective date of new benefits coverage will be the first of the month following receipt by the authority of the documentation required and the necessary application or applications, [~~provide~~] provided that all enrollment rules of the authority are met.

(7) Eligible employee enrollment after the enrollment period shall be permitted to only enroll in the authority's long-term disability plan and the voluntary life insurance plan upon providing the required evidence of medical insurability and approval by the disability and life carrier. Late enrollments shall not be permitted for medical, dental or vision coverages.

(8) If an eligible employee participant obtains dependent coverage for any eligible dependent from the authority, then the employee is required to enroll all eligible dependents in such coverage unless one or more eligible dependents have proof of other coverage. As an example: If an eligible employee participant is divorced, and the divorce decree states that medical coverage will be provided by the ex-spouse for one or more dependents of the eligible employee participant, the employee is permitted to enroll as a single in the medical and in the two party or family coverage for other lines of coverage.

(9) An employee is prohibited from having duplicate coverage from the authority for any line of coverage. An employee is also prohibited from having employee coverage and dependent coverage at the same time from the authority for any line of coverage. In the event of duplicate coverage, only one benefit will be paid. In those cases where an employee and [~~his or her~~] their spouse or domestic partner are both eligible employees, either one may enroll into the coverage and the other be treated as an eligible dependent.

(10) An eligible employee is not permitted to enroll for a particular line of coverage unless the minimum participation level as determined by the authority is met.

(11) The participant shall only be permitted to switch from one plan to another plan within the same line of coverage during an established switch enrollment period and then only under the terms and conditions permitted by the authority. Open enrollment is allowed annually to add a line of coverage under the terms and conditions provided by the authority.

(12) An employee may drop any line of coverage at any time at the employee's discretion, provided, however, any provision with respect to prohibition against dropping any lines of coverage shall be enforced as determined by the member. In divorce situations, a divorced eligible employee may not drop eligible dependents based on a change in status until a court-endorsed divorce decree is [~~filed with~~] provided to the member and processed by the authority. When a domestic partnership is terminated, the employee [~~ex-domestic partner~~] may not drop eligible dependents based on a change in status until the authority receives written notice from the employee that the domestic partnership is terminated in the form of an affidavit terminating domestic partnership provided to the member and processed by the authority. If the employee drops the line of coverage(s), the employee cannot re-enroll except as this part permits.

(13) Proper documentation, including evidence of medical insurability where required, must be provided by the eligible employee seeking coverage within 31 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.

(14) Eligibility for employee basic life [~~is~~] requires

the employee to be a benefits-eligible employee working a minimum of 15 hours or more per week, or as determined by the member.
[6.50.10.8 NMAC - Rp, 6.50.10.8 NMAC, 09/01/2014; A, 12/10/2024]

6.50.10.9 REQUIREMENTS FOR ENROLLMENT OF PART-TIME EMPLOYEES:

A. Part-time employees who work less than 20 hours a week but 15 hours per week or more are eligible for employee benefits if the member has passed a part-time resolution agreeing to provide employee benefits to part-time employees. A part-time resolution must be renewed in May of each year by the member and approved by the authority board in order for its [~~part-time~~] part-time employees to remain eligible for employee benefits.

B. Part-time employees who work less than 15 hours per week are not eligible for employee benefits.

C. Part-time employees eligible for employee benefits may also enroll their dependents.

[~~**D.**~~] The requirements for enrollment for [~~full time~~] full-time employees under 6.50.10.8 NMAC also apply to [~~part- time~~] part-time employees.

[~~**E.**~~] **D.** Eligibility for employee basic life [~~is~~] requires the employee to be a benefits-eligible employee working a minimum of 15 hours or more per week or as determined by the member.
[6.50.10.9 NMAC - N, 09/01/2014; A, 12/10/2024]

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 special enrollment. 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 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 61 calendar days of the date of placement.

B. The employee participant shall enroll the new eligible dependent within 31 calendar days of becoming an eligible dependent, except for newborns when family medical coverage is in effect at the time of the newborn's birth. Those persons considered to be a new eligible dependent are a newborn child, a new spouse, a domestic partner newly established by affidavit to be verified by the employer, a new legally adopted child, legal guardianship and other similar situations where the dependent becomes a new family member and is otherwise an eligible dependent pursuant to a court order. Supportive documentation in the form of copies of publicly filed marriage certificates, certificate of birth certificate information, guardianships, placement or adoption decrees and affidavits of domestic partnership shall be submitted along with the enrollment application.

C. An eligible dependent has no greater coverage than the eligible employee participant and the eligible dependent can maintain coverage only to the extent that the eligible employee participant maintains his coverage, except as otherwise specifically provided in this rule or to the extent federal law may grant broader rights. **D.** An eligible employee participant may drop any line of coverage for their eligible dependent at any time at the employee's discretion. However, any provision with respect to prohibition against dropping any lines of coverage shall be enforced as determined by the employer. If the employee drops the line of coverage, that employee cannot re-enroll the eligible dependent except as this rule permits. If the employee drops one dependent from a line of coverage, the employee must drop coverage on all eligible dependents except an employee may drop a dependent 18 years or above without dropping the other eligible dependents with supporting documentation or proof of application. In divorce situations, a divorced eligible employee may not drop eligible dependents based on a change in status until a court-endorsed divorce decree or mutual written court-endorsed stipulation is provided is filed with the authority. When a domestic partnership is terminated, the employee's ex-domestic partner may not drop eligible dependents based on a change in status until the authority receives written notice that the domestic partnership is terminated in the form of an affidavit terminating domestic partnership.

E. Proper documentation (together with application for coverage) including evidence of medical insurability where required, must be provided by the employee for the person seeking coverage within [~~61~~] 31 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.

F. An eligible retired employee and eligible dependents enrolled in a voluntary life plan prior to retirement and the retiree is less than age 70, shall be permitted to enroll in voluntary life [~~only during the established enrollment period~~] prior to life coverage expiring. The retiree shall be responsible for submitting enrollment paperwork and the first month's premium prior to [~~his retirement date~~] active coverage expiring to ensure no break in premium or coverage occurs. The retiree shall be responsible for premium payments for any monthly premiums. Retiree voluntary life coverage will extend through the last day of the month the retiree reaches age 70.

G. The established enrollment period allowed by the authority for active participating entity board members and eligible dependents is 31 calendar days after the board member has taken oath.

[6.50.10.10 NMAC - N, 09/01/2014; A, 10/1/2015; A, 12/10/2024]

6.50.10.13 ENROLLMENT AND ELIGIBILITY CONFLICTS:

A. In the event there is a conflict between a carrier's contract with the authority and this part regarding enrollment and eligibility, the carrier's contract shall prevail.

B. In the event there is a conflict between a carrier's contract with the authority and the policies of a participating entity regarding enrollment and eligibility, the carrier's contract shall prevail.

C. In the event there is a conflict between the policies of a participating entity policy and this part regarding enrollment and eligibility, this part shall prevail.

D. All disputes between a participating entity and an employee or [~~part time~~] part-time employee in determining eligibility shall be resolved at the participating entity level.

E. As to questions of enrollment and eligibility, if miscommunication to an employee or [~~part time~~] part-time employee by the participating entity has allegedly occurred, the participating entity shall provide a written statement to the authority indicating the party or parties who allegedly miscommunicated to the employee or [~~part time~~] part-time employee and the circumstances in which the alleged miscommunication occurred.

F. As to questions of enrollment and eligibility, disputes not resolved between an employee or [~~part time~~] part-time employee, the participating entity and the authority or its contractors shall be resolved according to the procedures of 6.50.16 NMAC of these rules. Paid premiums are to be determined by the employer.

G. As to all other conflicts between the authority and carriers, the relevant [~~conflicts~~] conflict provisions of the agreements between them shall control with regard to conflict resolutions.

[6.50.10.13 NMAC - N, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.12 NMAC, Sections 8, 9, 10, 11 and 12, effective 12/10/2024.

6.50.12.8 LOSS PREVENTION PROGRAM:

A. The loss prevention program is hereby created to provide a mechanism for the identification and abatement of hazards relating to all lines of coverage provided by the authority.

B. The loss prevention program is a service provided to the member school districts, charter schools and other educational entities in order to protect the insurance fund and its members from claims that could otherwise be prevented. The authority, through the program, provides recommendations for compliance to the members. It is the responsibility of the members to implement the recommendations for abatement.

C. All visits or inspections shall be performed by the [~~loss prevention representative (LPR)~~] risk management consultant (RMC).

D. The [~~LPR~~] RMC shall conduct evaluations of members. These evaluations shall include, but are not limited to:

(1) physical inspection of any or all of the members' structures, facilities, vehicles or equipment;

(2) review of the members' policies and procedures;

(3) observation of the members' scholastic and non-scholastic activities and operations; and

(4) interviews with members' administration, teachers, maintenance and other support personnel.

E. Within 25 working days following the [~~LPR~~] RMC's completion of the onsite evaluation of a member, the [~~LPR~~] RMC shall submit recommendations to the member for corrective action to eliminate the hazards or exposures observed.

F. Members shall have 20 working days from receipt of the [~~LPR~~] RMC's report to reply to the [~~LPR~~] RMC outlining their timetable for the implementation of recommendations, except for critical or imminent hazards as explained in Subsections G and H, below. If the hazard is not critical or imminent, upon request by the member, the [~~LPR~~] RMC may grant additional time up to no more than 60 working days from receipt of the [~~LPR~~] RMC's report for the member to reply.

G. Critical hazards are those hazards which have an above average potential for immediate occurrence, but are not immediately life threatening.

(1) The members shall have 10 working days from the receipt of the [~~LPR~~] RMC's report to provide an implementation schedule of recommendations identified by the [~~LPR~~] RMC as representing critical hazards.

(2) The [~~LPR~~] RMC shall make a request to the loss prevention review board (LPRB) that any operation involving the critical hazard be suspended if:

(a) the member fails to submit a report within 10 working days;

(b) the member refuses to provide a report within 10 working days; or

(c) the member does not satisfactorily fix the hazard within the time provided in the implementation schedule agreed upon or ordered.

H. Imminent hazards are those hazards which require suspension of activities or operations so as to avoid the threat of an occurrence which could reasonably be expected to cause death or serious physical harm before the danger can be eliminated through the recommended abatement.

(1) The [~~LPR~~] RMC shall convey any recommendation involving an imminent hazard immediately to the highest available member official.

(2) The [~~LPR~~] RMC shall require that any operations involving an imminent hazard be suspended pending implementation of the applicable recommendations.

(3) A notification of the imminent hazard, its accompanying recommendations, and any other verbal request made by the [~~LPR~~] RMC to the member shall be conveyed in writing to the executive director, LPRB, and the member within 72 hours.

(4) The member shall have 72 hours from the receipt of the notice of an imminent hazard to respond to the [~~LPR~~] RMC's recommendation and set forth a plan satisfactory to the [~~LPR~~] RMC to immediately abate the imminent hazard.

(5) The [~~LPR~~] RMC shall make a presentation to the chairperson of the LPRB and the executive director of the authority recommending that insurance coverage provided to the specific operation of the member be suspended if the member refuses or fails to submit a report within 72 hours regarding the immediate implementation of the [~~LPR~~] RMC's recommendation for abatement of the imminent hazard.

(6) The executive director and the [~~chairman~~] chairperson of the LPRB shall consider the recommendation of the [~~LPR~~] RMC and determine if the insurance coverage should be suspended pending a hearing before the LPRB under 6.50.12.11 NMAC.

I. The [~~LPR~~] RMC shall physically re-inspect the hazard or exposure to ensure adequate abatement compliance.

J. The [~~LPR~~] RMC shall provide loss prevention resource materials and activities where needed. These materials and activities shall include, but are not limited to:

(1) assisting members in the development of a member safety program when size and particular member activities warrant.

(2) providing sources for the procurement of [~~safety-related~~] safety-related literature, materials or services.

[6.50.12.8 NMAC - Rp, 6 50.12.8 NMAC, 09/01/2014; A, 12/10/2024]

6.50.12.9 LOSS PREVENTION REVIEW BOARD (LPRB):

A. The LPRB is hereby created to provide a mechanism for the review of loss prevention activities within the authority's jurisdiction. The LPRB is appointed by the board at the annual board meeting and, except as provided in Subsection B of this section, its membership shall be made up of the risk advisory committee.

B. In the event an LPRB is appointed in place of the risk advisory committee, it shall consist of five members, four of whom are appointed by the president of the authority board with the board's advice and consent. The risk advisory committee [~~chairman~~] chairperson shall be the fifth member of the LPRB and shall serve as the LPRB [~~chairman~~] chairperson.

C. The LPRB shall meet as required and as scheduled from time to time.

D. Special meetings may be called by the LPRB [~~chairman~~] chairperson, if [~~he~~] the chairperson determines the need for a special meeting is justified, upon the request of any LPRB or authority board member, any chief executive officer of any member, or the [~~LPR~~] RMC.

E. Notice of special meetings of the LPRB shall be sent to all LPRB members, the individual requesting the special meeting, and the [~~LPR~~] RMC.

F. The notice required in Subsection E above shall indicate the date, time and place of the special meeting. It shall also clearly set forth the purpose for which the meeting is being called, said purpose being the only matter the LPRB may consider and act upon at the special meeting.

[6.50.12.9 NMAC - Rp, 6 50.12.9 NMAC, 09/01/2014; A, 12/10/2024]

6.50.12.10 LOSS PREVENTION REVIEW BOARD DUTIES:

A. The LPRB shall consider and act upon:

(1) requests by the [~~LPR~~] RMC that a member be required to implement a specific recommendation;

(2) requests by a member that a recommendation by the [~~LPR~~] RMC be vacated;

(3) any other matter with regard to the enforcement of the authority's loss prevention management system not specifically covered in this part.

B. The LPRB shall recommend to the authority board claims management and claims adjusting procedures as they relate to abatement recommendations. Such procedures shall address documentation and management of claims files.

[6.50.12.10 NMAC - Rp, 6 50.12.10 NMAC, 09/01/2014; A, 12/10/2024]

6.50.12.11 LOSS PREVENTION REVIEW BOARD PROCEEDINGS: When considering a request as specified above, the LPRB [~~chairman~~] chairperson shall:

A. provide notification to all LPRB members, the [~~LPR~~] RMC, and the affected member;

B. conduct the meeting allowing the [~~LPR~~] RMC and the member representative the opportunity to present arguments and justifications for their respective requests, and permit members of the LPRB to ask questions of either party;

C. issue the decision of the LPRB within five days and:

(1) if the decision of the LPRB is in agreement with the member, the [~~LPR~~] RMC's recommendation shall be vacated;

(2) if the decision of the LPRB is in agreement with the [~~LPR~~] RMC, the recommendation shall be affirmed and the member directed to implement the recommendation;

(3) if the affirmed recommendation is not implemented as specified by the member, the [~~LPR~~] RMC shall refer the matter to the authority board for action.

[6.50.12.11 NMAC - Rp, 6 50.12.11 NMAC, 09/01/2014; A, 12/10/2024]

6.50.12.12 ENFORCEMENT: The responsibility for enforcement of LPRB decisions shall be vested in the authority board which may act as it sees fit to protect the integrity of the authority. These actions may include but are not limited to issuing a notice of no coverage, premium increase, or fines to the participating member. This notice shall state the specific circumstances for which coverage shall not be in effect, the reason for issuing the notice that no coverage is in effect and the date and time of inception of the no coverage notice. The notice of no coverage shall not affect any other area of coverage for the member. It shall only affect those specific circumstances stated in the notice of no coverage. Upon verification by the [~~LPR~~] RMC to the authority board in writing that a hazard giving rise to a notice of no coverage has been abated, the authority board shall cancel the notice of no coverage.

[6.50.12.12 NMAC - Rp, 6 50.12.12 NMAC, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.13 NMAC, Section 8, effective 12/10/2024.

6.50.13.8 SETTLEMENT POLICIES: The authority retains the right at its sole discretion to decide the terms and conditions of settlement of any claim against any authority insured. The authority or its third-party administrator will not settle a claim against an authority insured for an amount in excess of [~~$25,000~~] $50,000 without first notifying the authority insured of the proposed settlement and the rationale supporting the proposed settlement. After the authority or its third-party administrator has notified an insured of a proposed settlement, the authority or its third-party administrator retains the power to proceed to settle the claim as the authority or its third-party administrator deems it in the best interest of the authority. Should the insured object to the proposed settlement by the authority, the insured shall (if the proposed settlement is a payment of money damages) be offered a payment in an amount equal to the money damages proposed to be paid by the authority under the settlement. The offer to the insured shall be made on condition that the insured release the authority from any further liability on the claim. If the insured accepts the offer, the authority will not consummate the proposed settlement with the claimant. The insured shall then be responsible for defense and settlement or payment of any judgment with regard to the claim and the authority on payment of the settlement amount to the insured shall be released by the insured from all further responsibility for the claim.

[6.50.13.8 NMAC - Rp, 6 NMAC 50.13.8, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.14 NMAC, Sections 9 and 11, effective 12/10/2024.

6.50.14.9 WORKERS' COMPENSATION FORM POLICY FOR SCHOOL DISTRICTS, CHARTER SCHOOLS, OTHER EDUCATIONAL ENTITIES AND OTHER ENTITIES PARTICIPATING IN AUTHORITY WORKERS' COMPENSATION INSURANCE PROGRAM: All entities participating in the authority workers' compensation coverage shall adopt a policy substantially in the following form, selecting one of two options available for the selection of health care providers, for use of sick leave and for payment of insurance premiums while an employee is disabled from work.

A. Workers' compensation eligibility. In accordance with applicable workers' compensation statutes, all employees of (*insert name of participating entity*) who have a work-related injury are eligible for coverage.

B. Reporting accidents. An injured worker must report all work-related accidents or injuries immediately to [~~his~~] its immediate supervisor by completing and submitting the notice of accident form, whether or not medical care is needed. The worker's supervisor must then complete the supervisor's accident investigation report form. Both documents must be submitted to the employer's designated workers' compensation administrator within 24 hours from the time the supervisor is informed of the accident. The workers' compensation administrator then must complete the employer's first report of accident form and

forward all three forms to the [~~third-party~~] third-party administrator within 72 hours from the employer's first knowledge of the accident. The forms are available to download on the authority's website at: https://nmpsia.com.

C. Emergency medical treatment. When an injury or illness is life threatening in nature, the injured worker shall seek emergency treatment at the nearest emergency facility or by calling 911. After the emergency has abated, the injured worker will notify the employer in writing of the [~~work related~~] work-related injury and present any disability or return to work notices.

D. Selection of health care provider policy options.

(1) Each employer shall determine as a matter of policy whether it elects to initially select the [~~heath~~] health care provider or whether the injured worker is permitted to make the initial selection. Each employer shall also provide at the time of hiring or during employee orientation the following information in writing:

(a) Option 1 for selection of health care provider: (name of participating entity) elects to have injured workers treated at (insert name and location of facility); or

(b) Option 2 for selection of health care provider: (name of participating entity) permits the injured worker to initially select the health care provided as provided by Subsection B of Section 52-1-49 NMSA 1978.

(2) Upon notice of an accident or injury, the employer shall notify the injured worker in writing whether the employer's policy directs that medical care shall be provided by health care provider selected by the employer or whether the policy permits the worker to initially select the health care provider. The party who did not select the initial health care provider has the right to change to a different health care provider 60 days from the date the worker receives treatment from the selected provider.

E. Workers' compensation benefits.

(1) Medical benefits include all medical, surgical, and drug expenses that are reasonable, necessary and related to the work injury.

(2) Lost wage benefits are payments to a worker who is disabled from work in the opinion of an authorized health care provider and cannot earn wages. Lost wage benefits are based on a portion of [~~his~~] its average weekly wage up to a maximum limit set by the Workers' Compensation Act, Sections 52-1-1 et seq. NMSA 1978. The first seven days (consecutive or non-consecutive) is the statutory waiting period when no disability benefits are paid.

F. Sick leave and insurance premium payment options. Each employer shall determine as a matter of policy whether it elects to allow an injured worker to use paid time off during the initial seven days of the statutory waiting period and how [~~his~~] insurance premiums will be paid while [~~he is~~] disabled. There are only two options as follows:

(1) Employer Option #1:

(a) Use of sick leave: The initial seven day period that a worker is absent due to a [~~work related~~] work-related occurrence is the statutory waiting period in which no lost wage benefits are paid under the workers' compensation claim. The initial seven day period can be consecutive or non-consecutive days and must be charged to paid time off. If the worker continues to be disabled after the seven day waiting period, [~~he~~] they will be entitled to lost wage benefits equal to sixty-six and two-thirds percent of [~~his~~] their average weekly wage up to the statutory maximum allowed at the time of [~~his~~] injury. The worker is not permitted to use paid time off leave after the seven day waiting period. If the disability persists past 28 days, the worker will then be paid the lost wage benefits for the initial seven day waiting period and the worker is required to reimburse their paid time off bank;

(b) Payment of Insurance premiums: When an absence is due to a [~~work-related~~] work-related occurrence, the worker does not receive wages from the employer. During the period of disability, the worker shall pay [~~his~~] its portion of any insurance premiums for employer provided insurance directly to the employer. The employer will continue payment of its matching portion of the insurance premiums until the employee returns to work from the qualifying disability, through the end of the current fiscal year or for as long as the worker continues to pay [~~his~~] its portion of the premiums, whichever occurs first.

(2) Employer Option #2:

(a) Use of sick leave: The initial seven day period that a worker is absent due to a [~~work related~~] work-related occurrence is the statutory waiting period in which no lost wage benefits are paid under the workers' compensation claim. The initial seven day period can be consecutive or non-consecutive days and must be charged to paid time off. If the worker continues to be disabled after the seven day waiting period, [~~he~~] they will be entitled to lost wage benefits equal to sixty-six and two-thirds percent of [~~his~~] their average weekly wage up to the statutory maximum allowed at the time of [~~his~~] their injury. In order to allow the worker to maintain other employment benefits such as 401(k) contributions and health insurance premiums for family members and dependents, the worker is permitted to use paid time off leave in addition to workers' compensation benefits to equate to one hundred percent of the worker's gross wage. The worker will not be paid in excess of one hundred percent of his gross wages when both paid time off leave and compensation benefits are combined. The worker will not be entitled to any advancement of additional paid time off that the worker might potentially accrue during the balance of the fiscal year. If the disability persists past 28 days, the worker will then be paid the

lost wage benefits for the initial seven day waiting period and the worker is required notify the employer in writing for proper reimbursement their paid time off bank;

(b) Payment of Insurance premiums: When an absence is due to a [~~work-related~~] work-related occurrence, the worker does not receive wages from the employer. During the period of disability, the worker shall pay [~~his~~] their portion of any insurance premiums for employer provided insurance directly to the employer or if the worker uses paid time off leave, the worker's portion of the insurance premiums will continue to be deducted from the checks issued by the employer. The employer will continue payment of its matching portion of the insurance premiums until the employer returns to work from the qualifying disability, through the end of the current fiscal year or for as long as the worker continues to pay [~~his~~] their portion of the premiums, whichever occurs first.

G. Family medical leave act. Family medical leave act benefits [~~will~~] may run concurrently with the worker's time off for a [~~work-related~~] work-related injury.

H. Returning to work. Employees returning to work from a [~~work related~~] work-related disability shall:

(1) submit a written medical statement from the treating physician to the workers' compensation administrator that they are physically able to return to perform the essential job functions of the original position; and

(2) if physically unable to return to performance of the essential job functions of the original position, the worker shall submit a written medical statement from the treating physician for review by [~~his~~] their supervisor, human resources and the workers' compensation administrator detailing which specific functions of the original position that [~~he is~~] they are physically able to perform and which [~~he~~] they cannot; such written medical statement shall specify the employee's physical capacity in the terms outlined in Section 52-1-26.4, NMSA 1978; within five days of receiving this written notification, the employer shall advise the worker in writing of the availability of accommodating work and the start date on which the employee is expected to fill the accommodating position.

(3) If physically unable to perform even marginal job duties, the worker shall submit a written medical statement from the treating physician to the workers' compensation administrator to that effect for review by [~~his~~] their supervisor, human resources and the workers' compensation administrator; and

(4) present [~~himself~~] themselves for work within one working day after being released to return to work by his treating physician or of being notified of accommodating work by the employer.

I. Workers' compensation assessment fee. Workers covered by workers' compensation under the New Mexico Workers' Compensation Act, Sections 52-1-1 et seq., NMSA 1978 are required to pay a quarterly fee. The worker's contribution is taken as a quarterly payroll deduction.

[6.50.14.9 NMAC - Rp, 6 NMAC 50.14.9, 09/01/2014; A, 12/10/2024]

6.50.14.11 CLAIMS DETERMINATION: No school district, charter school or educational entity has the authority to accept or acknowledge liability for any workers' compensation claim. There is no liability for a workers' compensation claim until liability is acknowledged in writing by an authorized employee of the authority's [~~third party~~] third-party administrator.

[6.50.14.11 NMAC - Rp, 6 NMAC 50.14.11, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.16 NMAC, Sections 7, 13 and 15, effective 12/10/2024.

6.50.16.7 DEFINITIONS: As used in this rule:

A. "Authority" means the New Mexico public school insurance authority or its authorized representatives.

B. "Authority board" or **"board"** means the board of directors of the New Mexico public school insurance authority.

C. "Appellant" means any party who complains that a coverage determination may be in violation of any law, rule, regulation, or order administered or promulgated by the authority and who initiates a proceeding under this rule by filing a petition for review with the authority.

D. "Coverage determination" and **"determination"** mean any decision, order or disposition by the authority denying coverage, limiting the scope of coverage or limiting the amount of payment of a claim of a member or employee, except for workman's compensation claims.

E. "Document" means, except as otherwise used in the provisions of this rule governing discovery, any written submission in a formal proceeding which is not a pleading or which is required to be filed by authority rule or order outside a formal pleading; this includes items such as reports, exhibits, and studies; at the option of the party or staff making a filing, any document may additionally be presented in a form the hearing officer so orders.

F. "Employee" means a person employed by a member school district, charter school or other educational entity, or an employee's representatives in the event of legal incapacity, and includes volunteers or officials entitled to authority liability coverage pursuant to the Tort Claims Act, Subsection F of Section 41-4-3 NMSA 1978.

G. "Final coverage determination by the authority" with respect to a member means a coverage letter from the [~~authority's~~

~~contracted~~] authority in consultation with general counsel or contracted claims adjuster or with respect to an employee means a coverage letter from the authority's contracted third party benefits administrator or authorized authority staff member.

H. "Hearing" means any proceeding that is noticed for "hearing" by the authority or hearing officer and shall include an opportunity for the parties to present such evidence, argument, or other appropriate matters as the presiding officer shall deem relevant and material to the issues; hearings may be conducted by telephone conference call at the discretion of the presiding officer.

I. "Hearing officer" means a person appointed by the authority as a hearing examiner, who is designated by the authority to conduct any hearing or investigation which the authority is authorized to conduct, to take testimony in respect to the subject under investigation, report such testimony and provide to the authority a proposed decision with regard to the issues.

J. "Member school districts, charter schools and other participating entities" herein referred to collectively as **"members"** means all public school districts and charter schools mandated by the act to be members of the authority and all other educational entities voluntarily participating in the authority.

K. "Party" means any person or entity that initiates or responds to an authority proceeding by filing a petition for review with the authority and includes the authority; unless the context indicates otherwise, the term "party" may also refer to counsel of record for the party.
[6.50.16.7 NMAC - Rp, 6.50.16.7 NMAC, 09/01/2014; A, 12/10/2024]

6.50.16.13 PRE-HEARING PROCEDURE:

A. Hearing officer. The board shall appoint a hearing officer for an appeal within seven days after mailing the notice of setting. The board shall provide appropriate clerical support and space for any hearings conducted. Venue for any hearings shall be Santa Fe county unless the hearing officer in view of convenience to parties and witnesses orders that another location [~~is~~] or virtual attendance is more appropriate. The hearing officer shall oversee all proceedings after the hearing is set. The hearing officer will also provide written findings of fact and a disposition recommendation to the board within 14 days after completion of a hearing. The board shall make a final decision, after review of the recommendations of the hearing officer, and mail a notice of final decision to appellant within 30 days of receipt of the hearing officer's recommendations.

B. Representation of parties:

(1) The authority shall be represented in proceedings under this rule by its general counsel or a staff member of the authority appointed by the executive director for this purpose.

(2) The appellant may appear pro se, if appellant is an individual, or by an administrator of an institutional appellant who has been appointed for that purpose by the governing body of the institution. Any appellant may be represented by legal counsel licensed to practice law in the state of New Mexico.

C. Production of authority documents:

(1) Should a hearing be set by the board, the authority shall make available for copying and inspection all documents that the authority determines to be relevant to the initial determination being appealed within seven days of the date the hearing setting is issued. "Relevance," in this context is to be construed liberally in favor of production.

(2) Documents may be withheld or redacted by the authority only when the relevant material is protected from disclosure or otherwise privileged under New Mexico law. In the interest of complete disclosure, redaction shall be favored over withholding the document.

(3) Should any documents be withheld pursuant to New Mexico law, a list or privilege log generally identifying each document, its contents and the claimed privilege shall be provided to the appellant at the time of production.

(4) Documents produced shall be made available for inspection and copying at the offices of the authority.

D. Production of appellant or other party documents: The hearing officer for good cause shown may order inspection, production and copying of documents deemed relevant that are in the possession, custody or control of the appellant member, employee or other party.

E. Authority, appellant, member and employee arguments: At least 14 days before the date set for the hearing, all parties shall file simultaneously memorandums stating their complete arguments for or against the authority determination, including a statement of relevant facts, an outline of controlling law and the relief requested. Each party must mail or deliver the original memorandum and one copy to the hearing officer and one copy to the representative of each other party.

F. Witness and exhibit lists: Each party must file witness and exhibit lists at least 14 days before the date set for the hearing by mailing or delivering the original to the hearing officer and one copy to the representative of each other party. Witnesses must be identified with particularity. The party calling a witness must provide the witness's name and address and must describe the subject matter of the testimony expected to be elicited from each witness. Each document or object identified in the exhibit list must be immediately made available for inspection and copying. Only witnesses properly identified in the witness list will be permitted to testify in the hearing and only exhibits properly identified in the exhibit list will be admissible in the hearing unless upon good cause being

shown the hearing officer determines otherwise.
[6.50.16.13 NMAC - Rp, 6.50.16.13 NMAC, 09/01/2014; A, 12/10/2024]

6.50.16.15 CONFLICTS: If an employee or official of an aggrieved member is on the authority board, that authority board member shall abstain from any participation, discussion, action or voting with respect to the petition for review. In the event an aggrieved authority employee files a petition for review [~~he or she~~] the employee shall abstain from any participation, discussion, action or communication with regard to the petition other than in [~~his or her~~] the employee's normal role as a petitioner.
[6.50.16.15 NMAC - Rp, 6.50.16.15 NMAC, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.17 NMAC, Section 8, effective 12/10/2024.

6.50.17.8 POLICY ON USE OF SCHOOL FACILITIES BY PRIVATE PERSONS:

A. The representative of the requesting group shall contact the facilities manager or other designated school official of the desired site regarding the proposed usage within a time frame required by the site manager or official. The school or school district shall provide the requesting group with a site use agreement which sets forth the terms and conditions of use of the premises. Site use agreements shall at minimum include a copy of the school's safety rules or safety rules provided by the authority's risk management provider. The requesting group shall agree to follow the safety rules included with the site use agreement and also agree to follow the liability and risk related rules contained in Subsection G of 6.50.17.8 NMAC prior to use of the school facilities. The school facility use shall be conducted in compliance with all federal, state and municipal statutes, ordinances, rules and regulations including those with regard to discrimination. School facilities shall not be used for any unlawful purpose.

B. All groups shall also agree that the schools will not be liable for injury to the property of the group itself or participants in the group's activities resulting from their participation in the group's activities. Groups and their individual participants shall be required to give waivers of liability and releases for personal injury or property damage on forms provided by the school or the authority.

C. Liability insurance provided through the authority shall be excess over any valid and collectible insurance carried by any group permitted to use school facilities. Liability insurance provided by the authority for use of school facilities by private persons is limited to $1,000,000 per occurrence. Schools or school districts shall not warrant the suitability of the facility or of the facility's contents for the uses intended by the requesting group.

D. Commercial groups shall provide a copy of a current business license. Commercial groups shall inform participants that the activity is not sponsored by the school whose facilities are being used.

E. All districts shall include within their site use agreement a statement clearly indicating that the approved activity sponsor must assure that activity participants, guests and spectators only access those site areas designated for the activity. District superintendents shall also designate in the site use agreement an individual who shall verify that all the areas utilized were properly checked and secured upon departure from the facility.

F. Schools and school districts shall make their own arrangements regarding any payments required for use of the facilities, for reimbursement for special services such as setting up tables and chairs, use of school equipment such as projectors or video equipment or abnormal wear and tear on the facilities. All fees shall be made by check or money order and shall be made payable to the school or school board. It is inappropriate for users of school facilities to pay school employees directly for services in kind or in cash.

G. In addition to the safety rules included in the site use agreement, any user of school or school district facilities must agree to the following liability and risk related rules.

(1) The use of alcohol, illegal drugs and tobacco are prohibited on all school property at all times.

(2) Guns are not permitted on school property except for those in the possession of authorized law enforcement personnel.

(3) Users of the facility shall be responsible for providing security as required by the member school or school district for the type of function they have planned.

(4) Users of swimming pool facilities must have a certified lifeguard on duty at all times.

(5) For events that involve animals, including dogs, all must be leashed, penned, caged or otherwise properly contained, constrained or under supervision and control at all times. Animals or pets not properly contained, constrained or under supervision and control at all times are prohibited.

(6) Open fires including candles, torches, and bonfires shall not be allowed except pursuant to prior approval and permit by the appropriate authorities.

(7) Building exits shall never be blocked for any reason.

(8) Parking shall be in designated areas only.

(9) Every effort shall be made to provide vehicle and pedestrian traffic management in order to insure safe and orderly movement of vehicles and people.

(10) All care shall be taken in the design,

placement and construction of booths, displays, viewing stands, platforms, theater sets, temporary stages or any other structures to safeguard the safety of those building, using and disassembling such structures. Alterations made by the user shall be removed and the facility replaced to prior and current construction standards.

(11) Decorations shall be fire resistant whenever possible, cover no more than twenty percent of the wall area and never be placed within close proximity to incendiary sources.

(12) Care shall be taken at all times to avoid the creation of tripping hazards or if unavoidable to warn participants of obstacles.

(13) No hazardous materials, including pyrotechnic devises, fireworks, explosives flammable materials or liquids, poisonous materials or plants, strong acids or caustics shall be brought onto the premises or used in any way while occupying the premises except with the approval prior to use by the fire marshal or other authority having jurisdiction.

(14) No amusement rides or attractions, including but not limited to, trampolines of any type, enclosed or air supported structures of any type, climbing walls, climbing ropes, bow and arrow shooting activity or equipment or devises related thereto shall be brought onto the premises or used in any way while occupying the premises except with the express permission of school authorities and on proof of insurance by the user of the facility of at least $1,000,000 per occurrence naming the school or school district and the authority as additional insureds. All such activities shall be operated and overseen by persons experienced and, if possible, certified to do so.

(15) All users of school facilities shall give written notice to the school of any accident resulting in bodily injury or property damage to property of the school occurring on school premises or in any way connected with the use of the school premises within 24 hours of the accident. The notice shall include details of the time, place and circumstances of the accident and the names and addresses and phone numbers of any persons witnessing the accident.

(16) If playground equipment is to be used, the user of the facility shall provide at least one adult supervisor for every 15 children.

(17) The user of the facility shall provide the appropriate signage to inform participants of the safety rules. A list of emergency agencies and phone numbers shall also be posted.

(18) Access to school facilities by the users of the facility shall be limited to those areas specified in the site use agreement.

H. All users of school facilities shall agree to provide prompt and thorough clean-up and removal or storage of all special structures within no more than 24 hours after the end of the event, but in no case later than the beginning of the next school day or if school is out no later than prior to use of the area by school personnel. Users shall ensure that any furniture and equipment moved during the use of the facilities is replaced.

[6.50.17.8 NMAC - Rp, 6.50.17.8 NMAC, 09/01/2014; A, 12/10/2024]

PUBLIC SCHOOLS INSURANCE AUTHORITY

This is an amendment to 6.50.18 NMAC, Section 8, effective 12/10/2024.

6.50.18.8 POLICY FOR REGULAR VOLUNTEERS IN SCHOOLS AND SCHOOL DISTRICTS:

A. Participating member schools and school districts make extensive use of regular volunteers for many of their programs. In seeking and accepting the voluntary services of qualified, interested individuals, the participating members recognize that they have basic responsibilities to the regular volunteers as well as to the students and to themselves.

B. Each participating member shall be responsible for organizing and managing and documenting its own regular volunteer program subject to the following rules. Participating member schools, school districts and other educational entities shall have in place policies clearly establishing how and by whom regular volunteers are appointed and the policies at minimum shall require prior to services:

(1) Provide an application process for [~~interviewing~~] all prospective regular volunteers and doing [~~a~~] an FBI fingerprint background check, and a reference check including, but not limited to any history of drug abuse or drug dealing, domestic violence, DUI offenses, motor vehicle records checks, and [~~sex crimes~~] ethical misconduct in compliance with Section 22-10A-5 NMSA 1978;

(2) providing all regular volunteers with a job description, outlining specific duties, time commitment and qualifications for acceptance as a regular volunteer;

(3) providing appropriate training, supervision and evaluation of regular volunteers; and

(4) instructing all regular volunteers to understand that failure to obey the code of ethics and standards of professional conduct as provided in 6.60.9.8 NMAC and 6.60.9.9 NMAC concerning the obligations of school personnel is grounds for dismissal.

C. Regular volunteers shall not be allowed to begin their service until after their duties are explained to them and they have accepted in writing the following volunteer pledge. It is my duty:

(1) to deal justly and considerately with each student, school employee or other volunteer;

(2) to share the responsibility for improving educational opportunities for all;

(3) to stimulate students to think and learn, but at the same time protect them from harm;

(4) to respect the confidentiality of student records and information about students, their personal or family life;

(5) not to discriminate or to permit discrimination on the basis of race, color, national origin, ethnicity, sex, sexual orientation, disability, religion or serious medical condition against any person while I am on duty as a volunteer;

(6) to avoid exploiting or unduly influencing a student into engaging in an illegal or immoral ethical misconduct or act or any other behavior that would subject the student to discipline for misconduct, whether or not the student actually engages in the behavior;

(7) to avoid giving gifts to any one student unless all students similarly situated receive or are offered gifts of equal value for the same reason;

(8) to avoid lending money to students;

(9) to avoid having inappropriate contact with any student, whether or not on school property, which includes all forms of sexual touching, sexual relations or romantic relations, any touching which is unwelcome by the student or inappropriate given the age, sex and maturity of the student;

(10) to avoid giving a ride to a student;

(11) not to engage in sexual harassment of students, other volunteers or school employees;

(12) not to engage in inappropriate displays of affection, even with consenting adults, while on school property or during school events off premises;

(13) not to possess or use tobacco, alcohol, cannabis or illegal drugs while on school property or during school events off premises;

(14) to use educational facilities and property only for educational purposes or purposes for which they are intended consistent with applicable law, policies and rules;

(15) to avoid any violent, abusive, indecent, profane, boisterous, unreasonably loud or otherwise disorderly conduct when on school property or off campus at school functions;

(16) to abide by the school's social media policy to refrain from using school information technology equipment, hardware, software or internet access for other than a school related purpose;

(17) to refrain from striking, assaulting or restraining students unless necessary in the defense of self or others;

(18) to refrain from using inflammatory, derogatory or profane language while on school property or while attending school events off premises;

(19) to refrain from bringing or possessing firearms or other weapons on school property except with proper authorization;

(20) not to be under the influence of alcohol, cannabis or illegal drugs on school property or at school events off premises; and

(21) to report, as appropriate under the circumstances, violations of this pledge by other regular volunteers or school employees.

D. For the mutual protection of regular volunteers and the participating members, personnel administering regular volunteer programs shall provide a safe place to work and clear project organization or direction, establish and inform regular volunteers of emergency procedures, ensure that regular volunteers understand that their activities create participating member's liability, and that ethical standards apply to them as well as to regular school employees. Participating member personnel shall inform each regular volunteer in writing of the reserved right to dismiss unsatisfactory regular volunteers and of the established procedures for doing so.

E. Spontaneous volunteers are not subject to these rules, but spontaneous volunteers must be supervised at all times by an employee or regular volunteer of the school district, charter school or other educational entity.

[6.50.18.8 NMAC - Rp, 6.50.18.8 NMAC, 09/01/2014; A, 12/10/2024]

REGULATION AND LICENSING DEPARTMENT
CONSTRUCTION INDUSTRIES DIVISION

This is an amendment to 14.7.2 NMAC, Section 11, effective 01/13/2025.

14.7.2.11 CHAPTER 3 - OCCUPANCY CLASSIFICATION AND USE: See this chapter of the IBC except as provided below. [~~**Section 304 - Business Group B**. See this section of the IBC except as provided below. **Section 304.1 - Business group B.** See this section of the IBC and add the following to the list: Fire stations and police stations.~~]

A. Section 304 – Business Group B. See this section of the IBC except as provided below.

Section 304.1 – Business Group B. See this section of the IBC and add the following to the list: Fire stations and police stations.

B. Section 310 – Residential Group R. See this section of the IBC except as provided below. Section 310.4.1 Care facilities within a dwelling. Delete this section of the IBC and substitute with the following: Care facilities for 12 or fewer persons receiving care that are within a single-family dwelling are permitted to comply with 14.7.3 NMAC. The requirements of the automatic sprinkler system will not be required if a primary or secondary exit are provided to a public way.

[14.7.2.11 NMAC - Rp, 14.7.2.11 NMAC, 7/14/2023, A, 01/13/2025]

REGULATION AND LICENSING DEPARTMENT
CONSTRUCTION INDUSTRIES DIVISION

This is an amendment to 14.7.3 NMAC, Sections 9, 27, 28 and 29, effective 01/13/2025.

14.7.3.9 CHAPTER 1 SCOPE AND ADMINISTRATION: See this chapter of the IRC except as provided below.

A. Section R101 Scope and General Requirements.

(1) Section R101.1 Title. Delete this section of the IRC and substitute: This code shall be known as the 2021 New Mexico residential building code (NMRBC).

(2) Section R101.2 Scope. Delete this section of the IRC and see 14.7.3.2 NMAC, Scope and add the following: **Exception.** Live/work units complying with the requirements of Section 508.5 of the *International Building Code* shall be permitted to be built as one- and two-family *dwellings* or townhouses. Automatic fire sprinkler systems required by Section 903.2.8 of the *International Building Code* when constructed under the *International Residential Code for One- and Two-family Dwellings* shall conform to Section P2904 of the *Residential Building Code*. A home office or business not utilizing hazardous materials as defined in the international building code with a work area less than 300 sq. ft. is not a live/work unit subject to the requirements of the *International Building Code*. A home office in dwelling units exceeding 3000 sq. ft. may occupy up to ten percent of the floor area.

(3) Section R101.3 Purpose. See 14.7.3.6 NMAC, Objective.

B. Section R102 Applicability.

(1) Section R102.1 General. Delete this section of the IRC and see 14.5.1 NMAC, General Provisions.

(2) Section R102.2 Other laws. Delete this section of the IRC and see 14.5.1 NMAC, General Provisions.

(3) Section R102.3 Application of references. Delete this section of the IRC and see 14.5.1 NMAC, General Provisions.

(4) Section R102.4 Referenced codes and standards. Delete this section of the IRC and substitute the following: The codes referenced in the NMRBC are set forth below. See also 14.5.1 NMAC, General Provisions.

(a) Electrical. The NMEC applies to all electrical wiring as defined in Section 60-13-32 NMSA 1978. All references in the IRC to the international code council (ICC) electrical code are deemed references to the NMEC.

(b) Gas. The NMMC applies to "gas fittings" as that term is defined in Section 60-13-32 NMSA 1978. All references in the IRC to the international mechanical code are deemed references to the NMMC. Gas piping systems, and appliances for use with liquefied propane gas (LPG), or compressed natural gas (CNG), shall be governed by the LPG standards (Section 70-5-1 et seq. NMSA 1978, LPG and CNG Act, and the rules promulgated pursuant thereto, 19.15.4.1 through 19.15.4.24 NMAC.)

(c) Mechanical. The NMMC applies to the installation, repair, and replacement of mechanical systems including piping systems, equipment, appliances, fixtures, fittings, or appurtenances including ventilating, heating, cooling, air conditioning, and refrigeration systems, incinerators, and other energy related systems. All references in the IRC to the international mechanical code are deemed references to the NMMC.

(d) Plumbing. The NMPC applies to the installation, alterations, repairs, and replacement of plumbing systems, including piping systems, equipment, appliances, fixtures, fittings, and appurtenances, and where connected to a water or sewage system and all aspects of a medical gas system. All references in the IRC to the international plumbing code are deemed references to the NMPC.

(e) Energy. The NMRECC applies to all energy-efficiency-related requirements for the design and construction of buildings that are subject to the New Mexico construction codes. All references in the IRC to the international energy conservation code are deemed references to the NMRECC.

(5) Section R102.5 Appendices. This rule adopts the following appendices as amended herein.

(a) Appendix AH - Patio covers.

(b) Appendix AJ - Existing buildings.

(c) Appendix AK - Sound transmission.

(d) [~~Appendix AR - Light straw clay construction.~~] Appendix AM – Home day care R – 3 occupancy.

(e) [~~Appendix AS - Strawbale construction.~~] Appendix AR – Light straw clay construction.

(f) [~~Appendix AQ - Tiny Houses.~~] Appendix AS – Strawbale construction.

(g) Appendix AQ – Tiny Houses.

(6) Section R102.6 Partial invalidity. Delete this section of the IRC and see 14.5.1 NMAC, General Provisions.

(7) Section R102.7 Existing structures. See this section, and Subsection R102.7.1, Additions, Alterations or Repairs, of the IRC, except that the references to the International Property Maintenance Code and the International Fire Code are deleted.

C. Section R103 Department of Building Safety. Delete this section of the IRC.

D. Section R104 Duties and Powers of the Building Official. Delete this section of the IRC and see 14.5.1 NMAC, General Provisions.

E. Section R105 Permits. Delete this section of the IRC and see 14.5.2 NMAC, Permits.

F. Section R106 Construction Documents. Delete this provision of the IRC and see 14.5.2 NMAC, Permits.

G. Section R107 Temporary Structures and Uses. Delete this section of the IRC and see 14.5.2 NMAC, Permits.

H. Section R108 Fees. Delete this section of the IRC and see 14.5.5 NMAC, Fees.

I. Section R109 Inspections. Delete this section of the IRC and see 14.5.3 NMAC, Inspections.

J. Section R110 Certificate of Occupancy. Delete this section of the IRC and see 14.5.3 NMAC, Inspections.

K. Section R111 Service Utilities. Delete this section of the IRC and see 14.5.3 NMAC, Inspections.

L. Section R112 Board of Appeals. Delete this section of the IRC and see 14.5.1 NMAC, General Provisions.

M. Section R113 Violations. Delete this section of the IRC and see CILA 60-13-1 et seq., and 14.5.3 NMAC, Inspections.

N. Section R114 Stop Work Order. Delete this section of the IRC and see 14.5.3 NMAC, Inspections.

[14.7.3.9 NMAC – Rp, 14.7.3.9 NMAC, 7/14/2023; A, 01/13/2025]

14.7.3.27 [~~APPENDIX AQ TINY HOUSES:~~ ~~Delete this section of the IRC and substitute with the following sections.~~

~~**A. Section AQ101 General. Section AQ101.1 Scope.**~~ ~~This appendix shall be applicable to tiny houses used as single dwelling units providing complete independent living facilities for one or more persons, including permanent provisions for living, sleeping, eating, cooking, and sanitation and placed on a permanent foundation. Tiny houses shall comply with this code except as otherwise stated in this appendix. Tiny houses constructed in New Mexico or constructed outside New Mexico and transported into New Mexico shall be inspected to comply with New Mexico Residential Code requirements for instate or out of state production of dwelling units. This shall include Appendix Q of the New Mexico Residential Code. Tiny houses constructed on a chassis with permanent axle shall be considered recreational vehicles and shall meet codes for and be licensed as recreational vehicles so long as the axle remains in place. If axles are removed and the unit placed on supports (foundation) the unit must comply with code requirements for tiny houses placed on a permanent foundation. Tiny houses placed upon a permanent foundation shall be constructed to comply with New Mexico Building Residential Codes including Appendix AQ (Tiny Houses) of the IRC.~~

~~**B. Section AQ102 Definitions. Section AQ102.1 General Definitions.**~~ ~~The following words and terms shall, for the purposes of this appendix, have the meanings shown herein. Refer to Chapter 2 of the IRC for general definitions.~~

~~**(1) Emergency egress.**~~ ~~A skylight, roof window, or other emergency egress opening designed and installed to satisfy the emergency escape and rescue opening requirements in Section R310.2.~~

~~**(2) Landing platform.**~~ ~~A landing measuring two treads deep and two risers tall, provided as the top step of a stairway or ladder accessing a loft.~~

~~**(3) Loft**~~. ~~A floor level located more than 30 inches (762 mm) directly above the main floor and open to the main floor on at least one side with a ceiling height of less than 6 feet 8 inches (2032 mm), used as a living or sleeping space. The total area of all lofts shall not exceed 40 percent of the floor area.~~

~~**(4) Tiny house**~~. ~~A dwelling that is 400 square feet (37 m2) or less in floor area excluding lofts and does not include recreational vehicles.~~

~~**C. Section AQ103 Ceiling height. AQ103.1 Minimum ceiling height.**~~ ~~Habitable space and hallways in tiny houses shall have a ceiling height of not less than 6 feet 8 inches (2032 mm). Bathrooms, toilet rooms, and kitchens shall have a ceiling height of not less than 6 feet 4 inches (1930 mm). Obstructions shall not extend below these minimum ceiling heights including beams, girders, ducts, lighting, and other obstructions.~~ ~~**Exception:**~~ ~~Ceiling heights in lofts are permitted to be less than 6 feet 8 inches (2032 mm).~~

~~**D. Section AQ104 Lofts.**~~

~~**(1) Section AQ104.1 Minimum loft area and dimensions**~~. ~~Lofts used as a sleeping or living space shall meet the minimum area and dimension requirements of Sections AQ104.1.1 through AQ104.1.3.~~

~~**(a) Section AQ104.1.1 Minimum area.**~~ ~~Lofts shall have a floor area of not less than 35 square feet (3.25 m2).~~

~~**(b) Section AQ104.1.2 Minimum dimensions.**~~ ~~Lofts shall be not less than 5 feet (1524 mm) in any horizontal dimension.~~

~~**(c) Section AQ104.1.3 Height effect on loft area.**~~ ~~Portions of a loft with a sloping ceiling measuring less than 3 feet (914 mm) from the finished floor to the finished ceiling shall not be considered as contributing to the minimum required area for the loft.~~ ~~**Exception:**~~ ~~Under gable roofs with a minimum slope of 6:12. portions of a loft with a sloping ceiling measuring less than 16 inches (406 mm) from the finished floor to the finished ceiling shall not be considered as contributing to the minimum required area for the loft.~~

~~**(2) Section AQ104.2 Loft access.**~~ ~~The access to and primary egress from lofts shall be any type described in Sections AQ104.2.1 through AV104.2.4.~~

~~**(a) Section AQ104.2.1 Stairways.**~~ ~~Stairways accessing lofts shall comply~~

~~with this code or with Sections AQ104.2.1.1 through AQ104.2.1.5.~~

~~(i)~~

~~**Section AQ104.2.1.1 Width.** Stairways accessing a loft shall not be less than 17 inches (432 mm) in clear width at or above the handrail. The minimum width below the handrail shall be not less than 20 inches (508 mm).~~

~~(ii)~~

~~**Section AQ104.2.1.2 Headroom.** The headroom in stairways accessing a loft shall be not less than 6 feet 2 inches (1880 mm) as measured vertically from a sloped line connecting the tread or landing platform nosings in the middle of their width.~~

~~(iii)~~

~~**Section AQ104.2.1.3 Treads and risers.** Risers for stairs accessing a loft shall be not less than 7 inches (178 mm) and not more than 12 inches (305 mm) in height. Tread depth and riser height shall be calculated in accordance with one of the following formulas: (a) The tread depth shall be 20 inches (508 mm) minus 4/3 of the riser height. (b) The riser height shall be 15 inches (381 mm) minus 3/4 of the tread depth.~~

~~(iv)~~

~~**Section AQ104.2.1.4 Landing platforms.** The top tread and riser of stairways or ladders accessing lofts shall be constructed as a landing platform where the loft ceiling height is less than 6 feet 2 inches (1880 mm) at the point where the stairway or ladder meets the loft.~~

~~(v)~~

~~**Section AQ104.2.1.5 Handrails.** Handrails shall comply with Section R311.7.8.~~

~~(vi)~~

~~**Section AQ104.2.1.6 Stairway guards.** Guards at open sides of stairways shall comply with Section R312.1.~~

~~(b)~~

~~**Section AQ104.2.2 Ladders.** Ladders accessing lofts shall comply with Sections AQ104.2.1 and AQ104.2.2, including the requirements for handrails in section R311.7.8, and R308.4.6 glazing adjacent to stairs and ramps, and shall be permanently attached to the loft structure by a device that prevents movement during use. Attachment shall not be accomplished by use of toenails or nails subject to withdrawal.~~

~~(i)~~

~~**Section AQ104.2.2.1 Size and capacity.** Ladders accessing lofts shall have a rung width of not less than 12 inches (305 mm) and rungs shall be spaced with 10 inches (254mm) minimum to 14 inches (356mm) maximum spacing between rungs. Floor decking of lofts accessed by ladders shall be no more than 8½ feet above the main level floor. Ladders shall be capable of supporting a 200-pound (75 kg) load on any rung. Rung spacing shall be uniform within 3/8-inch (9.5 mm).~~

~~(ii)~~

~~**Section AQ104.2.2.2 Incline.** Ladders shall be installed at 70 to 80 degrees from horizontal.~~

~~(c)~~

~~**Section AQ104.2.3 Alternating tread devices.** Alternating tread devices accessing lofts shall comply with Sections R311.7.11 1 and R311.7.11.2. The clear width at and below the handrails shall be not less than 20 inches (508 mm).~~

~~(d)~~

~~**Section AQ104.2.4 Ships ladders.** Ships ladders accessing lofts shall comply with Sections R311.7.12.1 and R311.7.12.2. The clear width at and below handrails shall be not less than 20 inches (508 mm).~~

~~(e)~~

~~**Section AQ104.2.5 Loft Guards.** Loft guards shall be located along the open side of lofts. Loft guards shall not be less than 36 inches (914 mm) in height or one-half of the clear height to the ceiling, whichever is less.~~

~~**E. Section AQ105 Emergency escape and rescue openings: AQ105.1 General.** Tiny houses shall meet the requirements of Section R310 for emergency escape and rescue openings including lofts of 35 square feet or greater. Egress roof access windows in lofts shall be deemed to meet the requirements of Section R310 when installed with the bottom of their opening no more than 44 inches (1118 mm) above the loft floor.~~]

APPENDIX AM HOME DAY CARE – R3 OCCUPANCY: See this section of the IRC except as provided below. **Section AM103 Means of egress.** See this section of the IRC except as provided below. **Section AM 103.1 Exits required.** Delete this section of the IRC and substitute with the following: If the occupant load of the residence is more than 12, including those who are residents, during the time of operation of the day care, two exits are required from the ground level story.

[14.7.3.27 NMAC – Rp, 14.7.3.27 NMAC, 7/14/2023; A, 01/13/2025]

14.7.3.28 [~~APPENDIX AS STRAWBALE CONSTRUCTION:~~ ~~See this section of the IRC except as provided below. **Section AS101 General.** See this section of the IRC and add the following sections.~~

~~**A. Section AS101.3 Construction Documents.** Construction documents detailing the structural design of the structure shall be prepared by a licensed New Mexico architect or structural engineer. The architect or engineer stamp must be affixed to each page of the plans detailing construction of the structure with the design processionals signature and date affixed over each stamp.~~

~~**B. Section AS101.4 Certificate of Occupancy.** Prior to issuance of a certificate of occupancy by the construction industries division, an inspection report must be provided to the general construction inspector by the licensed New Mexico architect or structural engineer. The report shall attest to the building's structural integrity and conformance with the permitted drawings.~~]

APPENDIX AQ TINY HOUSES: Delete this section of the IRC and substitute with the following sections.

A. Section AQ101 General. Section AQ101.1 Scope. This appendix shall be applicable to tiny houses used as single dwelling units providing complete independent living facilities for one or more persons, including permanent

provisions for living, sleeping, eating, cooking, and sanitation and placed on a permanent foundation. Tiny houses shall comply with this code except as otherwise stated in this appendix. Tiny houses constructed in New Mexico or constructed outside New Mexico and transported into New Mexico shall be inspected to comply with New Mexico Residential Code requirements for instate or out of state production of dwelling units. This shall include Appendix Q of the New Mexico Residential Code. Tiny houses constructed on a chassis with permanent axle shall be considered recreational vehicles and shall meet codes for and be licensed as recreational vehicles so long as the axle remains in place. If axles are removed and the unit placed on supports (foundation) the unit must comply with code requirements for tiny houses placed on a permanent foundation. Tiny houses placed upon a permanent foundation shall be constructed to comply with New Mexico Building Residential Codes including Appendix AQ (Tiny Houses) of the IRC.

B. Section AQ102 Definitions. Section AQ102.1 General Definitions. The following words and terms shall, for the purposes of this appendix, have the meanings shown herein. Refer to Chapter 2 of the IRC for general definitions.

(1) Emergency egress. A skylight, roof window, or other emergency egress opening designed and installed to satisfy the emergency escape and rescue opening requirements in Section R310.2.

(2) Landing platform. A landing measuring two treads deep and two risers tall, provided as the top step of a stairway or ladder accessing a loft.

(3) Loft. A floor level located more than 30 inches (762 mm) directly above the main floor and open to the main floor on at least one side with a ceiling height of less than 6 feet 8 inches (2032 mm), used as a living or sleeping space. The total area of all lofts shall not exceed 40 percent of the floor area.

(4) Tiny house. A dwelling that is 400 square feet (37 m2) or less in floor area excluding lofts and does not include recreational vehicles.

C. Section AQ103 Ceiling height. AQ103.1 Minimum ceiling height. Habitable space and hallways in tiny houses shall have a ceiling height of not less than 6 feet 8 inches (2032 mm). Bathrooms, toilet rooms, and kitchens shall have a ceiling height of not less than 6 feet 4 inches (1930 mm). Obstructions shall not extend below these minimum ceiling heights including beams, girders, ducts, lighting, and other obstructions. **Exception:** Ceiling heights in lofts are permitted to be less than 6 feet 8 inches (2032 mm).

D. Section AQ104 Lofts.

(1) Section AQ104.1 Minimum loft area and dimensions. Lofts used as a sleeping or living space shall meet the minimum area and dimension requirements of Sections AQ104.1.1 through AQ104.1.3.

(a) Section AQ104.1.1 Minimum area. Lofts shall have a floor area of not less than 35 square feet (3.25 m2).

(b) Section AQ104.1.2 Minimum dimensions. Lofts shall be not less than 5 feet (1524 mm) in any horizontal dimension.

(c) Section AQ104.1.3 Height effect on loft area. Portions of a loft with a sloping ceiling measuring less than 3 feet (914 mm) from the finished floor to the finished ceiling shall not be considered as contributing to the minimum required area for the loft. **Exception:** Under gable roofs with a minimum slope of 6:12. portions of a loft with a sloping ceiling measuring less than 16 inches (406 mm) from the finished floor to the finished ceiling shall not be considered as contributing to the minimum required area for the loft.

(2) Section AQ104.2 Loft access. The access to and primary egress from lofts shall be any type described in Sections AQ104.2.1 through AV104.2.4.

(a) Section AQ104.2.1 Stairways. Stairways accessing lofts shall comply with this code or with Sections AQ104.2.1.1 through AQ104.2.1.5.

(i) Section AQ104.2.1.1 Width. Stairways accessing a loft shall not be less than 17 inches (432 mm) in clear width at or above the handrail. The minimum width below the handrail shall be not less than 20 inches (508 mm).

(ii) Section AQ104.2.1.2 Headroom. The headroom in stairways accessing a loft shall be not less than 6 feet 2 inches (1880 mm) as measured vertically from a sloped line connecting the tread or landing platform nosings in the middle of their width.

(iii) Section AQ104.2.1.3 Treads and risers. Risers for stairs accessing a loft shall be not less than 7 inches (178 mm) and not more than 12 inches (305 mm) in height. Tread depth and riser height shall be calculated in accordance with one of the following formulas: (a) The tread depth shall be 20 inches (508 mm) minus 4/3 of the riser height. (b) The riser height shall be 15 inches (381 mm) minus 3/4 of the tread depth.

(iv) Section AQ104.2.1.4 Landing platforms. The top tread and riser of stairways or ladders accessing lofts shall be constructed as a landing platform where the loft ceiling height is less than 6 feet 2 inches (1880 mm) at the point where the stairway or ladder meets the loft.

(v) Section AQ104.2.1.5 Handrails. Handrails shall comply with Section R311.7.8.

(vi) Section AQ104.2.1.6 Stairway guards. Guards at open sides of stairways shall comply with Section R312.1.

(b) Section AQ104.2.2 Ladders.

Ladders accessing lofts shall comply with Sections AQ104.2.1 and AQ104.2.2, including the requirements for handrails in section R311.7.8, and R308.4.6 glazing adjacent to stairs and ramps, and shall be permanently attached to the loft structure by a device that prevents movement during use. Attachment shall not be accomplished by use of toenails or nails subject to withdrawal.

(i) Section AQ104.2.2.1 Size and capacity. Ladders accessing lofts shall have a rung width of not less than 12 inches (305 mm) and rungs shall be spaced with 10 inches (254mm) minimum to 14 inches (356mm) maximum spacing between rungs. Floor decking of lofts accessed by ladders shall be no more than 8½ feet above the main level floor. Ladders shall be capable of supporting a 200-pound (75 kg) load on any rung. Rung spacing shall be uniform within 3/8-inch (9.5 mm).

(ii) Section AQ104.2.2.2 Incline. Ladders shall be installed at 70 to 80 degrees from horizontal.

(c) Section AQ104.2.3 Alternating tread devices. Alternating tread devices accessing lofts shall comply with Sections R311.7.11 1 and R311.7.11.2. The clear width at and below the handrails shall be not less than 20 inches (508 mm).

(d) Section AQ104.2.4 Ships ladders. Ships ladders accessing lofts shall comply with Sections R311.7.12.1 and R311.7.12.2. The clear width at and below handrails shall be not less than 20 inches (508 mm).

(e) Section AQ104.2.5 Loft Guards. Loft guards shall be located along the open side of lofts. Loft guards shall not be less than 36 inches (914 mm) in height or one-half of the clear height to the ceiling, whichever is less.

E. Section AQ105 Emergency escape and rescue openings: AQ105.1 General. Tiny houses shall meet the requirements of Section R310 for emergency escape and rescue openings including lofts of 35 square feet or greater. Egress roof access windows in lofts shall be deemed to meet the requirements of Section R310 when installed with the bottom of their opening no more than 44 inches (1118 mm) above the loft floor.

[14.7.3.28 NMAC - Rp, 14.7.3.28 NMAC, 7/14/2023; A, 01/13/2025]

14.7.3.29 APPENDIX AS STRAWBALE CONSTRUCTION: See this section of the IRC except as provided below. **Section AS101 General.** See this section of the IRC and add the following sections.

A. Section AS101.3 Construction Documents. Construction documents detailing the structural design of the structure shall be prepared by a licensed New Mexico architect or structural engineer. The architect or engineer stamp must be affixed to each page of the plans detailing construction of the structure with the design processionals signature and date affixed over each stamp.

B. Section AS101.4 Certificate of Occupancy. Prior to issuance of a certificate of occupancy by the construction industries division, an inspection report must be provided to the general construction inspector by the licensed New Mexico architect or structural engineer. The report shall attest to the building's structural integrity and conformance with the permitted drawings.

[14.7.3.29 NMAC - N, 01/13/2025]

REGULATION AND LICENSING DEPARTMENT
RESPIRATORY CARE ADVISORY BOARD

The New Mexico Advisory Board of Respiratory Care Practitioners approved the repeal of 16.23.14 NMAC, Respiratory Care Practitioners - Scope of Practice Guidelines for Non-Licensed, Non-Exempted Persons (filed 6/6/2000) and replace it with Respiratory Care Practitioners - Scope of Practice Guidelines for Non-Licensed, Non-Exempted Persons, (adopted 11/2/2024) and effective 12/10/2024.

REGULATION AND LICENSING DEPARTMENT
RESPIRATORY CARE ADVISORY BOARD

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 23 RESPIRATORY CARE PRACTITIONERS
PART 14 SCOPE OF PRACTICE GUIDELINES FOR NON-LICENSED, NON-EXEMPTED PERSONS

16.23.14.1 ISSUING AGENCY: New Mexico Regulation and Licensing Department, Respiratory Care Advisory Board.
[16.23.14.1 NMAC - Rp, 16.23.14.1 NMAC 12/10/2024]

16.23.14.2 SCOPE: The provisions in Part 14 of Chapter 23 apply to licensees and non-licensees.
[16.23.14.2 NMAC - Rp, 16.23.14.2 NMAC 12/10/2024]

16.23.14.3 STATUTORY AUTHORITY: Part 14 of Chapter 23 is promulgated pursuant to the Respiratory Care Act, Section 61-12B-11 NMSA 1978. Specifically, Sections 61-12B-2; 61-12B-3; 61-12B-4; 61-12B-7; Subsections C, D and E of Section 61-12B-9, Paragraph (7) of Subsection A of Sections 61-12B and 61-12B-15 NMSA 1978.
[16.23.14.3 NMAC - Rp, 16.23.14.3 NMAC 12/10/2024]

16.23.14.4 DURATION: Permanent.
[16.23.14.4 NMAC - Rp, 16.23.14.4 NMAC 12/10/2024]

16.23.14.5 EFFECTIVE DATE: December 10, 2024, unless a later date is cited at the end of a section.
[16.23.14.5 NMAC - Rp, 16.23.14.5 NMAC 12/10/2024]

16.23.14.6 OBJECTIVE: The objective of Part 14 of Chapter 23 is to clarify who can perform respiratory care-related functions and procedures. Its objective is also to clarify for non-licensed persons what respiratory care-related function, procedures, or services that they can legally perform, for instance, in the delivery of medical equipment in the home care setting, in accordance with the Respiratory Care Act, Sections 61-13-1 through 61-13-17 NMSA 1978.
[16.23.14.6 NMAC - Rp, 16.23.14.6 NMAC 12/10/2024]

16.23.14.7 DEFINITIONS:

A. "Department" means the New Mexico regulation and licensing department.

B. "DME or DME company" refers to durable medical equipment or companies that provide durable medical equipment in the health care industry.

C. [RESERVED]

D. "Gratuitous" means to receive no form of payment or remuneration.

E. "Home care setting" as it applies to respiratory care, means any facility, including a patient's home that would usually not employ respiratory care practitioners, specifically those facilities visited by a person from outside the facility to provide respiratory care services.

F. [RESERVED]

G. "License" Has the same meaning as defined in Subsection E of Section 61-1-2 NMSA 1978.

H. [RESERVED]

I. "Prescription" means an order given individually for the person for whom prescribed, either directly from the prescriber to the person licensed to fill the prescription or indirectly by means of a written order signed by the prescriber

J. "Medical direction" as applied to respiratory care, means a prescription or order by a physician authorized to practice medicine or by any other person authorized to prescribe under the laws of New Mexico.
[16.23.14.8 NMAC - Rp, 16.23.14.7 NMAC 12/10/2024]

16.23.14.8 RESPIRATORY CARE SCOPE OF PRACTICE: The scope of practice for respiratory care practitioners is clearly defined in Subsection C of Section 61-12B-3 NMSA 1978 and the respiratory care functions and procedures within the scope of practice of respiratory care practitioners are outlined in Subsection D of Section 61-12B-3 NMSA 1978. In order to perform these functions and procedures in New Mexico, a person must be licensed by the state under the Respiratory Care Act.
[16.23.14.8 NMAC - Rp, 16.23.14.8 NMAC 12/10/2024]

16.23.14.9 EXCEPTIONS TO LICENSURE: The following individuals are exempted from licensure under the Respiratory Care Act.

A. Persons licensed by other appropriate state agencies may perform the respiratory care functions and procedures provided in Section 61-12B-3 NMSA 1978, so long as they are authorized to do so by their profession's licensing body.

(1) The licensing body establishes and regulates the professional standards of the licensed profession; and

(2) The licensing body is obligated to enforce the provisions of its statutory mandate and the rules and regulations of that profession.

B. Persons who provide respiratory care-related self-care.

C. Persons, who do not represent themselves to be respiratory care practitioners, but who provide gratuitous care to friends or family members, or who provide respiratory care services in a case of emergency.

D. Persons who have demonstrated competency in one or more areas covered by the Respiratory Care Act may perform only those functions that they are qualified by examination to perform, as long as the testing body offering the examination is certified by the national commission for health certifying agencies.
[16.23.14.9 NMAC - Rp, 16.23.14.9 NMAC 12/10/2024]

16.23.14.10 VIOLATION OF THE RESPIRATORY CARE ACT SCOPE OF PRACTICE: It is a misdemeanor violation for anyone to perform respiratory care procedures that are regulated under the Respiratory Care Act unless licensed by the board; or unless exempted from licensure by the provisions in the Respiratory Care Act; or unless authorized under another licensed professional's license to perform respiratory care-related functions, procedures, or services.

A. The department may seek an immediate injunction to stop the illegal practice of respiratory care; or

B. The department may initiate civil action proceedings in any district court to enforce any of the provisions of the Respiratory Care Act.
[16.23.14.10 NMAC - Rp, 16.23.14.10 NMAC 12/10/2024]

16.23.14.11 UNLICENSED PERSONS NOT EXEMPTED BY THE RESPIRATORY CARE ACT: Persons who are not licensed in New Mexico to practice respiratory care, and who are not exempted from licensure by the Respiratory Care Act, particularly those persons employed by durable medical equipment companies, home care delivery, or other similar service companies may perform only the functions listed below. If a procedure, service, or function is not listed below, the non-licensed person may not legally perform it.
[16.23.14.11 NMAC - Rp, 16.23.14.11 NMAC 12/10/2024]

16.23.14.12 CPAP, BI-LEVEL WITHOUT BACK-UP RATE:

A. Deliver equipment and supplies.

B. Instruct the patient/family how to order supplies

C. Instruct the patient/

family who or where to call in case of emergency.
[16.23.14.12 NMAC - Rp, 16.23.14.12 NMAC 12/10/2024]

16.23.14.13 ORAL SUCTIONING:

A. Deliver equipment and supplies.

B. Instruct the patient/ family how to order supplies

C. Instruct the patient/ family or where to call in case of emergency
[16.23.14.13 NMAC - Rp, 16.23.14.13 NMAC 12/10/2024]

16.23.14.14 OXYGEN DELIVERY, SET UP, CARE, MONITORING, AND INSTRUCTION:

A. Deliver oxygen equipment and supplies.

B. Instruct the patient/ family how to order supplies

C. Connect the oxygen tubing or cannula to the oxygen equipment.

D. Instruct the patient/ family on the use of the cannula.

E. Instruct the patient/ family on how to turn the oxygen unit on.

F. Demonstrate to patient/family how to set the liter flow.

G. Instruct the patient/ family on how to connect and clean the humidifier bottle.

H. Instruct the patient/ family on oxygen safety.

I. Instruct the patient/ family on how to deal with equipment malfunction.

J. Instruct the patient/ family regarding the back-up oxygen cylinder.

K. Instruct the patient/ family who or where to call in case of emergency.
[16.23.14.14 NMAC - Rp, 16.23.14.14 NMAC 12/10/2024]

16.23.14.15 VENTILATOR/ LIFE SUPPORT:

A. Deliver ventilator and supplies.

B. Instruct the patient/ family how to order supplies.

C. Instruct the patient/ family who or where to call in case of emergency.
[16.23.14.15 NMAC - Rp, 16.23.14.15 NMAC 12/10/2024]

16.23.14.16 BRONCHIAL PULMONARY HYGIENE:

A. Deliver equipment and supplies.

B. Instruct the patient/ family how to order supplies.

C. Instruct the patient/ family who or where to call in case of emergency.
[16.23.14.16 NMAC - Rp, 16.23.14.16 NMAC 12/10/2024]

16.23.14.17 NASOTRACHEAL SUCTIONING:

A. Deliver equipment and supplies.

B. Instruct the patient/ family on how to order supplies.

C. Instruct the patient/ family who or where to call in case of emergency.
[16.23.14.17 NMAC - Rp, 16.23.14.17 NMAC 12/10/2024]

16.23.14.18 IPPB, NEBULIZER SET UP AND TREATMENT:

A. Deliver equipment and supplies.

B. Instruct the patient/ family how to order supplies.

C. Instruct the patient/ family who or where to call in case of emergency.
[16.23.14.18 NMAC - Rp, 16.23.14.18 NMAC 12/10/2024]

16.23.14.19 APNEA MONITOR:

A. Deliver equipment and supplies.

B. Instruct the patient/ family on how to order supplies.

C. Instruct the patient/ family who or where to call in case of emergency.
[16.23.14.19 NMAC - Rp, 16.23.14.19 NMAC 12/10/2024]

16.23.14.20 DIAGNOSTIC TESTING:

A. Deliver equipment and supplies.

B. Instruct the patient/ family on how to order supplies.

C. Instruct the patient/ family who or where to call in case of emergency.
[16.23.14.20 NMAC - Rp, 16.23.14.20 NMAC 12/10/2024]

16.23.14.21 TRACHEOSTOMY CARE:

A. Deliver equipment and supplies.

B. Instruct the patient/ family on how to order supplies.

C. Instruct the patient/ family who or where to call in case of emergency.
[16.23.14.21 NMAC - Rp, 16.23.14.21 NMAC 12/10/2024]

16.23.14.22 [RESERVED]

16.23.14.23 [RESERVED]

16.23.14.24 UNLICENSED PRACTICE OF RESPIRATORY CARE - DISCIPLINARY GUIDELINES: In accordance with the provisions contained within the Uniform Licensing Act, the department may take disciplinary action as provided in Section 61-1-3.2, NMSA 1978, (2003 Repl. Pamp.) if the department, in consultation with the board, determines that the respondent has violated the Respiratory Care Act or the department's rules and regulations governing respiratory care (16.23 NMAC) by practicing respiratory care in New Mexico without a valid New Mexico license.

A. The department, in consultation with the board, may impose a civil penalty in an amount not to exceed one thousand dollars ($1,000) against a person who, without a license, engages in the practice of respiratory care.

B. The department, in consultation with the board, may impose a civil penalty in an amount not to exceed one thousand dollars ($1,000) against a company or other business entity that requires an unlicensed person to engage in the practice of respiratory care without a license. The penalty shall be imposed

in the amount of one thousand dollars ($1,000) for each individual that the company or business entity employs and who is performing respiratory care scope of practice procedures and protocols without benefit of a valid New Mexico respiratory care license or permit.

C. In addition, the department, in consultation with the board may assess the person, company, or other business entity for administrative costs, including investigative costs and the cost of conducting a hearing.

[16.23.14.23 NMAC - Rp, 16.23.14.23 NMAC 12/10/2024]

HISTORY of 16.23.14 NMAC:
[RESERVED]

HISTORY OF REPEALED MATERIAL:
16.23.14 NMAC, "Scope of Practice Guidelines For Non - Licensed, Non - Exempted Persons filed 6/6/2000 - Repealed effective 12/10/2024.

Other History: 16.23.14 NMAC, "Scope of Practice Guidelines For Non - Licensed, Non - Exempted Persons filed 6/6/2000 - Replaced by 16.23.14 NMAC, "Scope of Practice Guidelines For Non - Licensed, Non - Exempted effective 12/10/2024.

REGULATION AND LICENSING DEPARTMENT
RESPIRATORY CARE ADVISORY BOARD

This is an amendment to 16.23.1 NMAC, Section 7 and 16 effective 12/10/2024.

16.23.1.7 DEFINITIONS: Unless otherwise defined below, terms used in Title 16, Chapter 23 NMAC, have the same meanings as set forth in the Respiratory Care Act or in other cited New Mexico statutes:

A. Definitions beginning with "A":

(1) **"Applicant"** means a person who has applied to the department for a temporary permit or a respiratory care practitioner's license.

(2) **"Approval"** means the review and acceptance of a specific activity.

(3) **"Approval body"** means the agency, institution, or organization with the authorization to award continuing education credit.

(4) **"Approved training and education program**" means a program supported by the commission accreditation for respiratory care (COARC), or its predecessor the joint review committee for respiratory therapy education (JRCRTE) or accredited by the commission on accreditation of allied health education programs (CAAHEP), or its successor approval body.

(5) **"Audit"** means an examination and verification of continuing education documents by the department.

B. Definitions beginning with "B": "**Board"** has the same meaning as defined in Subsection A of Section 61-12B-3 NMSA 1978.

C. Definitions beginning with "C":

(1) **"Clock hour"** means a unit of measurement to describe a continuing education offering which equals a 60-minute clock hour.

(2) **"Complaint"** means a complaint, which has been filed with the department or the board, against a temporary permittee, respiratory care practitioner licensee, or applicant for either permit or license.

(3) **"Complainant"** means the party who files a complaint against a temporary permittee, a respiratory care practitioner licensee, or an applicant for either a permit or a license governed by the Respiratory Care Act.

(4) **"Continuing education" or "CE"** means a learning experience intended to enhance professional development and includes continuing education units (CEUs) and continuing medical education (CME).

(5) **"Controlled Substances Act"** refers to Section 30-31-1 through Section 30-31-41 NMSA 1978.

(6) **"CRT"** means certified respiratory therapist. This is the entry level of respiratory care.

(7) **"CRTT"** means a certified respiratory therapy technician. This is the entry level of respiratory care.

D. Definitions beginning with "D":

(1) **"Department"** has the same meaning as defined in Subsection B of Section 61-12B-3 NMSA 1978.

(2) **"Direct supervision"** means direction and control by a training supervisor over a student extern temporary permittee or a graduate temporary permittee while the permittee is providing respiratory care procedures under the authority of the training supervisor's license.

(3) **"DME or DME company"** refers to durable medical equipment or companies that provide durable medical equipment in the health care industry.

E. Definitions beginning with "E":

(1) **"Electronic signature"** has the same meaning as defined in Subsection 7 of Section 14-16-2 NMSA 1978.

(2) **"Expired license"** means a license that has not been renewed on or before the end of the license renewal period.

(3) **"Expanded practice"** has the same meaning as the definition in Subsection E of Section 61-12B-3 NMSA 1978.

F. Definitions beginning with "F": "**Facility"** means the employer of a licensed respiratory care practitioner or temporary permit holder.

G. Definitions beginning with "G":

(1) **"Graduate"** means a non-licensed person who has completed an approved respiratory care training program and is employed by a

supervisory facility to provide respiratory care for remuneration and in accordance with the provisions for a temporary permit issued under these regulations.

(2) "Gratuitous" means to receive no form of payment or remuneration.

H. Definitions beginning with "H": "Home care setting" as it applies to respiratory care, means any facility, including a patient's home that would usually not employ respiratory care practitioners, specifically those facilities visited by a person from outside the facility to provide respiratory care services.

I. Definitions beginning with "I":

(1) "Impaired Health Care Provider Act" refers to Section 61-7-1 through Section 61-7-12 NMSA 1978.

(2) "Initial licensure" [~~means the process of achieving the legal privilege to practice within a professional category upon the completion of educational and other licensing requirements.~~] Has the same meaning as defined in Subsection D of Section 61-1-2 NMSA 1978.

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

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

L. Definitions beginning with "L":

(1) "Lapsed license" means an expired license which has not been reactivated within the time limitations set forth in Section 17 in 16.23.1 NMAC.

(2) "License" [~~means a document identifying the legal privilege and authorization to practice within a professional category. In the context of military and veterans' applications submitted pursuant to 16.23.5 NMAC, "license"~~] has the same meaning as defined in [~~Paragraph (1) of Subsection F of Section 61-1-34 NMSA 1978~~] Subsection E of Section 61-1-2 NMSA 1978.

(3) "License reactivation" means the process of making current a license that has expired as a result of failure to comply with the necessary renewal requirements.

(4) "Licensing period for extern permits" means a one-year period from the date of issuance to the last day of the same month, one year later.

(5) "Licensing period for graduate permits" means six months from the date of application and is not renewable; or until receipt of failing national board of respiratory care (NBRC) registered respiratory therapist (RRT) exam results. Initial applicants who do not become licensed within one year of becoming (NBRC) credentialed are issued a one year graduate permit from the date of application.

M. Definitions beginning with "M":

(1) "Medical board" as it applies to respiratory care, means a group of medical experts that review clinical practice in a facility to assure that the practice of health care meets the standard of care in the health care community.

(2) "Medical direction" as it applies to respiratory care, means a prescription or order by a physician authorized to practice medicine or by any other person authorized to prescribe under the laws of New Mexico.

(3) "Military service member" has the same meaning as defined in Paragraph (3) of Subsection F of Section 61-1-34 NMSA 1978.

N. Definitions beginning with "N":

(1) "NBRC" means the national board for respiratory care, inc.

(2) "National licensing exam" means the national examination for respiratory care practitioners administered by the national board for respiratory care resulting in obtaining CRTT, CRT, or RRT credentials.

(3) "Non-traditional training program" refers to a respiratory care training program in which a person receives on-the-job training in respiratory care from a supervising medical director, a supervising physician, or a licensed respiratory care practitioner, and in which the trainee may receive compensation while in such a training program.

(4) "Notice of contemplated action" or "NCA" means the administrative action provided for by the Uniform Licensing Act, whereby the respondent is given notice of a pending disciplinary action against his or her application, permit or license, based upon violations of the department's rules and regulations governing the practice of respiratory care or the Respiratory Care Act, which have been alleged in a complaint filed with the department or the board. The respondent is afforded an opportunity for a formal hearing before the department, in consultation with the board.

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

P. Definitions beginning with "P":

(1) "Prescription" means an order given individually for the person for whom prescribed, either directly from the prescriber to the person licensed to fill the prescription or indirectly by means of a written order signed by the prescriber.

(2) "Parental Responsibility Act" or "PRA" refers to Section 40-5A-1 through Section 40-5A-13, NMSA 1978 (1995 Supp.) herein referred to as the Parental Responsibility Act or PRA.

(3) "Permittee" means a person who has been granted a temporary permit by the department, in consultation with the board.

(4) "Public health emergency" is an emergency declared pursuant to the All Hazards Emergency Management Act, Sections 12-10-1 to 12-10-21 NMSA 1978, and the Public Health Emergency Response Act, Sections 12-10A-1 to 12-10A-19 NMSA 1978.

(5) "Public Records Act" refers to Section 14-3-1 through Section 14-3-25, NMSA 1978.

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

R. Definitions beginning with "R":

(1) **"Redacted"** means the act or process of editing or revising the complaint so that the parties, which are the subject of the complaint, are unknown to the board.

(2) **"Reinstatement"** means the process whereby a license that has been subject to revocation or suspension is returned to former status.

(3) **"Respiratory Care Act"** refers to Section 61-12B-1 through Section 61-12B-16, NMSA 1978.

(4) **"Respiratory Care Practitioner" or "RCP"** means a person who is licensed to practice respiratory care in New Mexico.

(5) **"Respiratory Therapy Training Program"** means a program approved by the commission on accreditation of allied health education programs (CAHEP), or its successor approval body.

(6) **"Respondent"** means the permit or license applicant or the temporary permittee or licensed practitioner who is the subject of the complaint.

(7) "RRT" means a registered respiratory therapist. This is the advanced level of respiratory care.

S. Definitions beginning with "S":

(1) "Student" means a person enrolled in an approved respiratory care training and education program and who receives *no remuneration* for respiratory care services performed in a supervisory facility as part of an approved respiratory care training program.

(2) "Student extern" means a person who is engaged by a supervisory facility to provide respiratory care for remuneration while enrolled in an approved respiratory care training and education program, and in accordance with the provisions for a temporary permit issued under these regulations.

(3) **"Superintendent"** has the same meaning as defined in Subsection I of Section 61-12B-3 NMSA 1978.

(4) **"Supervisory facility"** means the employer of a temporary permit holder.

T. Definitions beginning with "T":

(1) **"Telemedicine"** means the use of telephonic or electronic communications to provide clinical services to patients without an in-person visit.

(2) **"Traditional training program"** refers to a respiratory care training program that provides classroom instruction and clinical experience only to students or student externs under direct supervision of a licensed and responsible professional.

(3) "Training supervisor" means a New Mexico licensed respiratory care practitioner or a New Mexico licensed physician who agrees to be responsible for the respiratory care administered by student externs and graduates while these individuals are employed by a supervisory facility and are being trained there.

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

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

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

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

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

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

[16.23.1.7 NMAC - Rp, 16.23.1.7 NMAC, 6/27/2023, A, 11/19/2024]

16.23.1.16 INACTIVE STATUS REQUIREMENTS: Currently licensed practitioners who are not currently practicing in New Mexico under the terms and provisions authorized by the Respiratory Care Act, or who are working for the federal government, may place their licenses on inactive status at the time of renewal rather than let their licenses expire. A practitioner's license will be placed on inactive status by the department after the licensee has provided the following:

A. A practitioner's license will be placed on inactive status by the department after the licensee has provided the following:

(1) a completed renewal application signed by the applicant under penalty of perjury, on which the "inactive status requested" box has been checked;

(2) documentation verifying that the continuing education requirements were met as set forth 16.23.12 NMAC; and

(3) the applicable fee for inactive status set forth in 16.23.2.8 NMAC.

B. the practitioner must submit the completed renewal application [~~form~~] marked for inactive status [~~with a postmark dated~~] on or before September 30 in order to be processed for inactive status.

C. Upon approval of the inactive status application request, the department will send the licensee notice that the license has been placed on inactive status.

D. Until the inactive status license has been reactivated, the respiratory care practitioner may not practice respiratory care in New Mexico unless employed by the federal government.

E. Inactive status reactivation: The individual who has placed his or her license on inactive status may reactivate the license before September 30 of the next odd-numbered year by completing the following procedure.

(1) complete, sign, and submit the reactivation application [~~provided by the department~~]; and

(2) payment of any applicable fee for reactivation from inactive status set forth in 16.23.2.8 NMAC.

F. Upon approval of the reactivation application, the department will issue a reactivated

license to the licensee. The license number will remain the same.

G. Continuing education requirements for reactivation: For the next renewal cycle, the number of continuing education hours that will be required will depend upon the reactivation date as follows:

(1) Twenty clock hours per renewal cycle. If the completed reactivation application is received by the department [~~postmarked~~] *on or before* September 30 of the *even*-numbered year, the number of continuing education hours due at the next renewal (September 30 of the next odd-numbered year) will be 20 hours.

(2) Ten clock hours per renewal cycle. If the completed reactivation application is received by the department [~~postmarked~~] on or after October 1 of the *even*-numbered year through May 31 of the odd-numbered year, the number of continuing education hours due at the next renewal (September 30 of the same year) will be 10 hours.

(3) Zero clock hours. If the completed reactivation application is approved by the department [~~postmarked~~] on or after June 1 of the *odd*-numbered (renewal) year through July 31 of the same year, the number of continuing education hours due at the next renewal (September 30 of the same year) will be zero hours.

[16.23.1.16 NMAC - Rp, 16.23.1.16 NMAC, 6/27/2023; A, 12/10/2024]

REGULATION AND LICENSING DEPARTMENT
RESPIRATORY CARE ADVISORY BOARD

This is an amendment to 16.23.3 NMAC, Sections 9 and 17, effective 12/10/2024.

16.23.3.9 INITIAL LICENSURE REQUIREMENTS: The board only recognizes accreditation by the commission on accreditation for respiratory care (CoARC) or its successor approval body. All references to the national board examinations in this part are to the national board for respiratory care, [~~inc~~] (NBRC) examination. In accordance with Section 61-12B-7 and Section 61-12B-8, NMSA 1978, and the qualifications set forth therein, the applicant must provide verification of the following:

A. successful completion of an accredited respiratory care education program;

B. proof of passing the NBRC examination resulting in credentialing as a registered respiratory therapist or RRT and maintaining a current RRT credential; or

C. Applicants for licensure must provide the following items of documentation to the department:

(1) A complete application [~~on forms~~] provided by the board.

[~~**(2)** An acceptable form of identification, including the following:~~

~~**(a)** a document issued by a federal, state, county, or municipal government, or a political subdivision or agency thereof, including, but not limited to, a valid motor vehicle operator's license that contains the name, date of birth and photo of the person;~~

~~**(b)** a valid identification card issued to a member of the Armed Forces that includes the person's name, date of birth, and photo of the person; or~~

~~**(c)** a valid passport issued by the United States or by a foreign government.~~

~~**(3)**~~] **(2)** A copy of an official transcript, certificate or diploma showing completion of an approved respiratory care program, or a letter sent directly from the program director prior to matriculation.

[~~**(4)**~~] **(3)** A copy of one of the following documents from the NBRC:

(a) identification card from the NBRC confirming that the applicant holds a current RRT credential; or

(b) the examination results showing successful passing of the NBRC, RRT examination if the applicant has not yet received the NBRC certificate;

(c) a verification letter from the NBRC showing CRT (prior to January 1, of 2018 in New Mexico or another United States jurisdiction), or RRT credential;

[~~**(5)**~~] **(4)** [~~Payment applicable.~~] Payment of any applicable fee set forth in 16.23.2.8 NMAC.

[~~**(6)**~~] **(5)** Verification of licensure, to include any disciplinary history, by all jurisdictions where the applicant is or has ever been licensed.

(6) Jurisprudence examination with a passing score of seventy-five percent or higher. Each applicant will be afforded three opportunities to pass the exam. If the applicant has not achieved a passing score after three attempts, the applicant must wait three months before attempting to retake the exam.

D. If applicable, those returning to the field and are applying for new licensure shall meet the requirements set in this rule.

E. After the above listed documentation has been reviewed and approved by the department, in consultation with the board, the applicant will be issued a respiratory care practitioner's license valid until September 30 of the next odd numbered year.

[16.23.3.9 NMAC - Rp, 16.23.3.9 NMAC, 6/27/2023, A, 12/10/2024]

16.23.3.17 RENEWAL DEADLINE: The deadline for renewal of current respiratory care practitioner licenses is September 30 of each odd-numbered year.

A. September 30 postmark requirement. Completed renewal applications must be [~~postmarked or~~] completed on-line on or before September 30 of the renewal year.

B. Application rejected. Incomplete renewal

applications will be rejected by the board.

C. Late renewal. Any renewal application received after September 30 of the renewal year, is expired and must be accompanied by the fee required for reactivation.
[16.23.3.17 NMAC - Rp, 16.23.3.17 NMAC, 6/27/2023, A, 12/10/2024]

REGULATION AND LICENSING DEPARTMENT
RESPIRATORY CARE ADVISORY BOARD

This is an amendment to 16.23.5 NMAC, Sections 10 and 11 effective 12/10/2024.

16.23.5.10 EXPEDITED LICENSE APPLICATION:

A. A candidate for expedited licensure must submit to the board a complete application containing all of the following:

(1) A completed and signed application [~~form~~].

(2) Proof of current unrestricted licensure in good standing held by the applicant in an eligible jurisdiction(s).

(3) Payment of the required application fee set forth in 16.23.2.8 NMAC.

B. An expedited license application shall not be deemed complete until the applicant has submitted [~~and the board's staff is in receipt of all of the materials~~] a complete application, including documentation from third parties, required by subsection A.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal conviction or the board or superintendent may have other cause to deny the application pursuant to 61-12B-12 NMSA 1978:

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting and then provided to the superintendent for final action;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the superintendent may grant the application or refer the matter to an administrative prosecutor for denial of the application as provided by the board's rules.

(4) Jurisprudence examination with a passing score of seventy-five percent or higher. Each applicant will be afforded three opportunities to pass the exam. If the applicant has not achieved a passing score after three attempts, the applicant must wait three months before attempting to retake the exam.

[16.23.5.10 NMAC - N, 6/27/2023, A, 12/10/2024]

16.23.5.11 EXPEDITED LICENSURE APPPLICATION FOR MILITARY SERVICE MEMBERS, SPOUSES AND VETERANS:

A. A candidate for expedited licensure must submit to the board a complete application containing all of the following:

(1) a completed and signed application [~~form~~];

(2) proof of current license in good standing in another jurisdiction, including a branch of the United States armed forces; and

(3) submission of the following documentation:

(a) for military service member: a copy of military orders;

(b) for spouse of military service members: copy of military service member's military orders, and copy of marriage license;

(c) for spouses of deceased military service members: copy of decedent's DD 214 and copy of marriage license;

(d) for dependent children of military service members: a copy of military service member's orders listing dependent child, or a copy of military orders and one of the following: a copy of birth certificate, military service member's federal tax return or other governmental or judicial documentation establishing dependency; or

(e) for veterans (retired or separated), proof of honorable discharge, such as a copy of DD Form 214, DD Form 215, DD Form 256, DD Form 257, NGB Form 22, military ID card, driver's license or state ID card with a veteran's designation, or other documentation verifying honorable discharge.

B. An expedited license application shall not be deemed complete until the applicant has submitted [~~and the board's staff is in receipt of all of the materials~~] a complete application, including documentation from third parties, required by Subsection A.

C. Upon receipt of a complete application, the board's staff shall process the application and issue the expedited license to a qualified applicant within 30 days.

D. If the applicant has a potentially disqualifying criminal conviction or the board or superintendent may have other cause to deny the application pursuant to Section 61-12B-12 NMSA 1978.

(1) the matter of the applicant's application shall be submitted to the board for consideration and action at its next available regular meeting and then provided to the superintendent for final action;

(2) the license may not be issued within 30 days of submission of the complete application; and

(3) the superintendent may grant the application or refer the matter to an administrative prosecutor for denial of the application as provided by the board's rules.

E. A military service member or veteran who is issued an expedited license shall not be charged any initial licensing fees or renewal fees for the first three years of licensure with the board.
[16.23.5.11 NMAC - N, 6/27/2023, A, 12/10/2024]

REGULATION AND LICENSING DEPARTMENT
RESPIRATORY CARE ADVISORY BOARD

This is an amendment to 16.23.6 NMAC, Sections 9, 10 and 23. effective 12/10/2024.

16.23.6.9 APPLICATION REQUIREMENTS FOR STUDENT EXTERNS: The department, in consultation with the board, will issue temporary permits to respiratory care student externs enrolled in a traditional or non-traditional respiratory care training program approved as set forth in Paragraph (4) of Subsection A and Paragraph (5) of Subsection R of 16.23.1 NMAC, or by the board and who provide satisfactory evidence of the following:

A. Verification of current respiratory care program enrollment sent directly by the educational institution to the department.

[~~**B.** A color passport-type photograph taken within the past year.~~

~~**C.**~~] **B.** A notarized statement or letter sent by the applicant's direct supervisor confirming the location and status of the applicant's employment.

[~~**D.**~~] **C.** An agreement signed by the proposed training supervisor made under penalty of perjury, which certifies that the supervisor will provide training and direct supervision which meets the requirements of these regulations.

[~~**E.**~~] **D.** A temporary permit application [~~form~~] approved and provided by the department, completed by the applicant, and signed by the applicant attesting that the information on the application is complete under penalty of perjury.

[~~F.~~] E. Payment to the board in the amount set forth in Subsection A of 16.23.2.8 NMAC.
[16.23.6.9 NMAC - Rp, 16.23.6.9 NMAC, 04/21/2022, A, 12/10/2024]

16.23.6.10 APPLICATION REQUIREMENTS FOR GRADUATES: The department, in consultation with the board, will issue non-renewable temporary permits to non-licensed graduates from an approved respiratory care training and education program (see Subsections E and GG of 16.23.6.1 NMAC), and who provide the following:

A. the required items listed in of Subsections B, C, D and E of 16.23.6.9 NMAC;

B. a copy of the applicant's graduation certificate or diploma from an approved respiratory care training and educational program; or

C. the applicant's graduate transcript [~~sent directly to the department by the educational institution~~]; or an official copy of the transcripts [~~sent directly from the program~~]; or a letter [~~sent directly~~] from the program director prior to matriculation; and

D. proof of good faith attempts and reasonable progress in pursuing the NBRC credentialing as a RRT, by providing a copy of the letter scheduling the applicant for the NBRC, or RRT credentialing examination if the applicant has not taken the credentialing examination previously but, is scheduled to sit for it.
[16.23.6.10 NMAC - Rp, 16.23.6.10 NMAC, 04/21/2022 A, 12/10/2024]

16.23.6.23 RENEWAL REQUIREMENTS AND PROCESS FOR STUDENT TEMPORARY PERMITS:

A. At least 45 days before the temporary permit expiration date, the department will [~~mail~~] email the permittee a temporary permit renewal notice and an application [~~form~~] to apply for permit renewal.

B. Renewal application notices will be [~~mailed~~] emailed to the last [~~residential~~] email address on file. [~~with the department.~~] It is the permittee's responsibility to request a renewal [~~form~~] application if one has not been received 30 days prior to the permit expiration date.

C. The department will send the permittee's training supervisor a copy of the renewal notice, which was sent to the permittee.

D. All applicants for temporary permit renewal must meet the following requirements:

(1) Complete and sign a renewal application [~~form~~] approved by the department.

(2) Submit [~~a check or money order payable to the board for~~] the required fee as provided in 16.23.4.8 NMAC. [~~whichever is applicable.~~]
[16.23.6.23 NMAC - Rp, 16.23.6.23 NMAC, 04/21/2022, A, 12/10/2024]

REGULATION AND LICENSING DEPARTMENT
RESPIRATORY CARE ADVISORY BOARD

This is an amendment to 16.23.12 NMAC, Section 8. effective 12/10/2024.

16.23.12.8 CONTINUING EDUCATION REQUIREMENTS: The completion of 20 clock hours of continuing education is a requirement for biennial license renewal or license reactivation.

A. Continuing education hours must be directly related to respiratory therapy, pulmonary function technology, or related inter-disciplinary areas of health care.

B. All licensees must complete at least one hour of ethics related continuing education in the license renewal cycle.

C. Effective October 25, 2025, all licensees must complete at least one hour of human trafficking

related continuing education in the license renewal cycle.

[~~C.~~] **D.** The department may consult with the board to resolve questions as to appropriate continuing education hours.

(1) The department shall be the final authority on acceptance of any educational activity submitted by a licensee or a sponsor for approval.

(2) Each respiratory care practitioner must participate in at least 20 clock hours of continuing education activities every renewal cycle, or as provided by 16.23.12.12 NMAC and 16.23.12.13 NMAC.

[~~D.~~] **E.** A minimum of [~~twelve~~] 12 clock hours of the [~~twenty~~] 20 clock hours of continuing education must be consistent with American Medical Association Category I, which includes any of the following types of educational offerings:

(1) lecture - a discourse given for instruction before an audience or through teleconference;

(2) panel - a presentation of a number of views by several professionals on a given subject with none of the views considered a final solution;

(3) workshop - a series of meetings for intensive, hands on, study or discussion, in a specific area of interest;

(4) seminar - a directed advanced study or discussion in a specific field of interest;

(5) symposium - conference of more than a single session organized for the purpose of discussion of a specific subject from various viewpoints and by various presenters;

(6) distance education - includes such enduring materials as text, internet or CD, provided the provider has included an independently scored test as part of the learning package; and

(7) NBRC-awarded continuing education credit for successful completion of re-credentialing examination(s) for renewal of credential as a CRT (if the CRT was issued prior to January 1, 2018) or RRT.

[16.23.12.8 NMAC - Rp, 16.23.12.8 NMAC, 04/21/2022, A, 12/10/2024]

SUPERINTENDENT OF INSURANCE, OFFICE OF

The New Mexico Superintendent of Insurance repealed its rule 13.4.2 NMAC, Resident Producers And Other Resident Licenses, filed 04/02/2018, and replaced it with a new rule entitled Resident Producers and Other Resident Licenses, 13.4.2 NMAC, adopted 11/25/2024 and effective 4/01/2025.

The New Mexico Superintendent of Insurance repealed its rule 13.4.3 NMAC, Nonresident Agents and Brokers, filed 11/30/2001, and replaced it with a new rule entitled Nonresident Producers, 13.4.3 NMAC, adopted 11/25/2024 and effective 4/01/2025.

The New Mexico Superintendent of Insurance repealed its rule 13.4.4 NMAC, Surplus Line Brokers filed 11/30/2001, and replaced it with a new rule entitled Surplus Line Brokers 13.4.4 NMAC, adopted 11/25/2024 and effective 4/01/2025.

The New Mexico Superintendent of Insurance repealed its rule 13.4.7 NMAC, Continuing Education Requirements filed 2/27/2018, and replaced it with a new rule entitled Continuing Education Requirements, 13.4.7 NMAC, adopted 11/25/2024 and effective 4/01/2025.

SUPERINTENDENT OF INSURANCE, OFFICE OF

TITLE 13 INSURANCE
CHAPTER 4 LICENSING OF INSURANCE PROFESSIONALS
PART 2 RESIDENT PRODUCERS AND OTHER RESIDENT LICENSES

13.4.2.1 ISSUING AGENCY: Office of Superintendent of Insurance (OSI).
[13.4.2.1 NMAC – Rp, 13.4.2.1 NMAC, 04/01/2025]

13.4.2.2 SCOPE: This rule applies to persons seeking licensure to engage in insurance-related activities as defined in Articles 1 and 7 of Chapter 59A NMSA 1978 and who shall be licensed pursuant to articles of the Insurance Code.
[13.4.2.2 NMAC – Rp, 13.4.2.2 NMAC, 04/01/2025]

13.4.2.3 STATUTORY AUTHORITY: Chapter 59A, Articles 11, 12, 12A, 12B and 13 and Section 59A-2-9 NMSA 1978, and 18 U.S.C. Section 1033.
[13.4.2.3 NMAC – Rp, 13.4.2.3 NMAC, 04/01/2025]

13.4.2.4 DURATION: Permanent.
[13.4.2.4 NMAC – Rp, 13.4.2.4 NMAC, 04/01/2025]

13.4.2.5 EFFECTIVE DATE: April 1, 2025, unless a later date is cited at the end of a section.
[13.4.2.5 NMAC – Rp, 13.4.2.5 NMAC, 04/01/2025]

13.4.2.6 OBJECTIVE:

A. Covered by this rule. The purpose of this rule is to implement Chapter 59A, Articles 11, 12, 12A, 12B and 13 NMSA 1978 and Section 59A-2-9 NMSA 1978, and other articles within the Insurance Code that address licensing of insurance professionals by the superintendent of insurance. This rule establishes requirements for obtaining a license as a resident insurance producer, insurance consultant, producer for prepaid dental plans, producer for sales of membership in a health maintenance organization, producer for a fraternal benefit society, vendor selling portable electronics insurance, salesperson for prearranged funeral plans, title insurance producer, reinsurance intermediary, managing general agent, registered motor club

representative, rental car insurance producer or endorsee, temporary insurance producer or travel insurance producer. This rule also establishes requirements for qualifying examinations and the issuance, duration, continuation and termination of all such licenses, appointments and registrations, referred to herein as "licenses."

B. Covered under other rules. For licensing of bail bondsmen and their solicitors, refer to 13.20.2 NMAC. For licensing of surplus lines brokers, refer to Section 59A-14-1 et seq. NMSA 1978 and 13.4.4 NMAC. For licensing of resident annuity or securities salespersons, refer to Section 59A-35-1 et seq. NMSA 1978 and 13.3.6 NMAC. For licensing of staff, independent and public adjusters refer to Section 59A-13-1 et seq. NMSA 1978 and 13.4.8 NMAC. For licensing of third-party administrators, refer to 13.4.5 NMAC. For appointment of licensed producers to transact credit life and credit health insurance, refer to Section 59A-25-1 et seq. NMSA 1978 and 13.18.2 NMAC. For licensing of pharmacy benefit managers, refer to Section 59A-61-1 et seq. NMSA 1978 and other OSI rules.

[13.4.2.6 NMAC – Rp, 13.4.2.6 NMAC, 04/01/2025]

13.4.2.7 DEFINITIONS: For the purposes of this rule:

A. "affiliate" means a person that controls, is controlled by or is under common control with an insurance producer;

B. "appointment" means official authorization by an insurer of a licensed producer to transact insurance on the insurer's behalf upon application and the payment of required fees by the insurer to the superintendent;

C. "broker" means a type of insurance producer who, not being an agent of the insurer, but as an independent contractor and on behalf of the insured, solicits, negotiates or procures insurance or annuity contracts or the renewal or continuation thereof for insureds or prospective insureds other than the broker. In any controversy between an insured or an insured's beneficiary and the insurer issuing the insurance through its licensed insurance producer at the request of a broker, the broker shall be held to be the agent of the insured unless under particular circumstances it is found that the broker is representing the insurer or in instances of fraud or attempted fraud by the insured. "Broker" does not include a surplus lines broker as defined in Chapter 59A, Article 14 NMSA 1978;

D. "business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity;

E. "central registration depository" or **"CRD"** means the national program overseen by the financial industry regulatory authority that supports the licensing and registration filing requirements of the United States securities industry and its regulators by maintaining registration records of broker-dealer firms, branch offices and their associated individuals, including their qualification, employment and disclosure histories; the CRD also directs the processing of form filings, fingerprint submissions, collection and disbursement of registration-related fees, qualification exams and continuing education sessions;

F. "compensation" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes or any other form of valuable consideration, whether or not payable pursuant to a written agreement;

G. "designated home state" means a state in which an insurance producer is licensed and which the producer designates for purposes of compliance with licensing regulations;

H. "designated responsible licensed producer" or **"DRLP"** is as defined in Subsection B of 13.4.2.10 NMAC;

I. "errors and omissions policy" or **"professional indemnity insurance"** means a form of casualty insurance that helps to protect individuals and companies from costs of defending against a negligence claim based on allegations of loss caused by an error or omission in the service sold;

J. "escrow" means a transaction in which funds are delivered or given to a person not otherwise having any right, title or interest in them, to be held by that person for delivery or disbursement to another person upon the occurrence of a specified event or the performance of a specified condition;

K. "financial industry regulatory authority" or **"FINRA"** means the not-for-profit organization authorized by Congress that oversees United States securities broker-dealers;

L. "home state" means the District of Columbia or any state or territory of the United States which is the principal place of residence or principal place of business for an insurance producer and in which the producer is licensed to transact insurance;

M. "insurance" has the meaning set forth in Section 59A-1-5 NMSA 1978;

N. "insurance consultant" means a person who, under an agreement with an insured or potential insured, provides professional advice regarding a policy, annuity or other instrument of insurance in exchange for a fee, as set forth in Section 59A-11A-1 NMSA 1978.

O. "insurance producer" means a person required to be licensed in this state to sell, solicit or negotiate insurance. A licensed insurance producer appointed by an insurer shall, in any controversy between an insured or an insured's beneficiary and the insurer, be held to be the agent of the insurer that issued the insurance solicited or applied for;

P. "insurer" has the meaning set forth in Section 59A-1-8 NMSA 1978;

Q. "license" means a document issued by the superintendent of insurance

authorizing a person to act as an insurance producer for the lines of authority specified in the document or to engage in other insurance transactions based on the type of license;

R. "limited lines insurance" means those lines of insurance as set forth in Sections 59A-12-18, 59A-12-18.1 and 59A-60-1 et seq. NMSA 1978, or any other line of insurance that the superintendent deems necessary;

S. "limited lines insurance producer" means a licensed insurance producer who is qualified to solicit and sell limited lines insurance;

T. "managing general agent" means a specialized type of licensed insurance producer as defined in Subsection C of Section 59A-12B-2 NMSA 1978;

U. "NAIC" means the national association of insurance commissioners;

V. "negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers;

W. "offer and disseminate" means providing general information, such as a description of coverage and price, processing applications, collecting premiums and performing other insurance-related activities for which a license is not required by this state;

X. "prearranged funeral plan" means a contract for future delivery of a funeral plan as defined in Subsections A, B and C of Section 59A-49-4 NMSA 1978;

Y. "prepaid dental plan" means a contractual arrangement whereby a prepaid dental plan organization undertakes to directly provide or to arrange for the provision of prepaid dental services and to pay or make reimbursement for any remaining portion of such prepaid dental services on a prepaid basis through insurance or otherwise;

Z. "principal" means a person who gives authority to another to act on the person's behalf;

AA. "rental car endorsee" means a rental car agent's employee who offers, sells, binds, effects, solicits or negotiates rental car insurance and who satisfies the requirements of Subsection C of 13.4.2.15 NMAC;

BB. "rental car insurance" means insurance sold in connection with and incidental to the rental of a vehicle and that applies only to the vehicle that is the subject of the rental agreement, and as further defined in Subsection E of Section 59A-32A-2 NMSA 1978;

CC. "rental car producer" means a person or entity in the business of renting rental cars to the public and that is licensed to offer, sell, bind, effect, solicit or negotiate rental car insurance;

DD. "resident of the state" means an individual who maintains a principal home in New Mexico and holds no active resident insurance license in another state;

EE. "sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer;

FF. "service representative" means an individual regularly employed and salaried by an insurer, group of insurers or managing general agent who assists insurance producers in soliciting, negotiating and effectuating insurance for the insurer, group or managing general agent and who, in the conduct of their business, receives no part of the commission on insurance written. A service representative is not required to be licensed, nor shall the service representative independently solicit or negotiate insurance or annuity contracts;

GG. "solicit" means to attempt to sell insurance or ask or urge a person to apply for a particular kind of insurance from a particular insurer;

HH. "superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization;

II. "terminate" means to cancel the relationship between an insurance producer and the insurer or to terminate a licensed insurance professional's authority to transact insurance;

JJ. "title abstract plant" is as defined in Section 59A-12-13 NMSA 1978;

KK. "title insurance policy" means an insurance contract indemnifying against loss or damages, as set forth in Subsection H of Section 59A-30-3 NMSA 1978;

LL. "title insurance business" means the types of business set forth in Subsection C of Section 59A-30-3 NMSA 1978;

MM. "title insurance producer" is a person licensed in this state to engage in the business of title insurance and who has been appointed to perform escrow, closing and settlement functions of a real estate transaction by a title insurer;

NN. "travel insurance policy" means insurance coverage for personal risks incident to planned travel as defined in Paragraph (3) of Subsection H of Section 59A-12-18.1 NMSA 1978; and

OO. "travel retailer" means a business entity that makes, arranges or offers travel services.

[13.4.2.7 NMAC – Rp, 13.4.2.7 NMAC, 04/01/2025]

13.4.2.8 TYPES OF INSURANCE LICENSES:

A. License required.

(1) No individual or business entity shall sell, solicit or negotiate insurance in this state unless licensed by the superintendent as an insurance producer for that line of insurance. Any person who is compensated for soliciting or accepting applications for health maintenance organization membership from the public shall be licensed as a health insurance

producer in accordance with the provisions of Section 59A-46-17 NMSA 1978.

(2) A business entity that is licensed as an insurance producer shall employ licensed individual insurance producers to transact the types of insurance for which the business entity is licensed. Such an individual insurance producer shall hold a license of the same type as that of the business entity employer.

(3) Persons who engage in other transactions that are subject to the Insurance Code shall be licensed according to requirements set forth under relevant sections.

B. Producer license types based on lines of authority. An insurance producer may be qualified for one or more of the following lines of authority:

(1) casualty insurance, including coverage against legal liability, including for death, injury, disability or damage to real or personal property;

(2) property insurance, including coverage for direct or consequential loss or damage to property of every kind;

(3) accident and health or sickness insurance, including coverage for sickness, bodily injury or accidental death and may include benefits for disability income;

(4) life insurance, including coverage on human lives, benefits of endowment and annuities, and other benefits in the event of death or dismemberment by accident and may include benefits for disability income;

(5) variable life and variable annuity insurance, including contracts deemed to constitute securities that require that the producer also possess a license as a security salesman under other applicable state laws; and

(6) personal lines, including property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

C. Producer licenses for limited lines. An insurance producer may also be licensed for any of the following limited lines:

(1) credit insurance, as sold by individual producers who are employed full time by a vendor of merchandise or other property or by a financial institution that executes consumer loans which require credit life insurance, credit disability insurance, credit property insurance or credit involuntary unemployment insurance as set forth in Section 59A-25-1 et seq. NMSA 1978;

(2) travel insurance, as sold by producers who are qualified to solicit or sell travel insurance as set forth in Section 59A-12-18.1 et seq. NMSA 1978 and 13.4.2.14 NMAC;

(3) portable electronics insurance, as sold by vendors and their employees and representatives in accordance with the provisions of the Portable Electronics Insurance Act found at Section 59A-60-1 et seq. NMSA 1978 and as set forth in 13.4.2.21 NMAC;

(4) rental car insurance, as sold in connection with and incidental to the rental of vehicles by a rental car company and in accordance with the provisions of the Rental Car Insurance Limited Producer License Act found in Section 59A-32A-1 et seq. NMSA 1978 and as set forth in 13.4.2.15 NMAC;

(5) title insurance, as sold by title insurance business entities and the title insurance producers employed by them in accordance with the provisions of the New Mexico Title Insurance Law found in Section 59A-30-1 et seq. NMSA 1978 and as set forth in 13.4.2.13 NMAC; or

(6) motor club services, as sold by a registered representative and provided by a motor club holding a certificate of authority in this state in accordance with the provisions of the Motor Club Law found in Section 59A-50-1 et seq. NMSA 1978 and as set forth in 13.4.2.16 NMAC.

D. Other licenses required. Persons engaging in any of the following types of transaction under the insurance code shall also be licensed:

(1) persons offering membership in a prepaid dental plan in accordance with the provisions of the Prepaid Dental Plan Law found in Section 59A-48-1 et seq. NMSA 1978 and as set forth in 13.4.2.18 NMAC;

(2) persons engaged in the sale of prearranged funeral plans in accordance with the provisions of the Prearranged Funeral Plan Regulatory Law found in Section 59A-49-1 et seq. NMSA 1978 and as set forth in 13.4.2.19 NMAC;

(3) persons offering benefits to members through a fraternal benefit society as set forth in Section 59A-44-1 et seq. NMSA 1978 and 13.4.2.20 NMAC;

(4) persons acting as reinsurance intermediaries in accordance with the provisions of the Reinsurance Intermediary Law found at Section 59A-12D-1 et seq. NMSA 1978 and as set forth in 13.4.2.22 NMAC;

(5) persons selling services as insurance consultants in accordance with the provisions of Section 59A-11A-1 et seq. NMSA 1978 and as set forth in 13.4.2.23 NMAC;

(6) third-party administrators performing or providing any service, function, duty or activity in respect to any insurance plan, self-insurance or alternative to insurance in an administrative or management capacity in this state with respect to risks located or partially located in this state or on behalf of persons in this state in accordance with the provisions of Section 59A-12A-1 et seq. NMSA 1978 and as set forth in 13.4.5 NMAC;

(7) persons acting as independent, public and staff adjusters in accordance with the provisions of Section 59A-13-1 et seq. NMSA 1978 and as set forth in 13.4.8 NMAC; and

(8) persons acting as surplus lines brokers in accordance with the provisions of Section 59A-14-1 et seq. NMSA 1978 and as set forth in 13.4.4 NMAC.
[13.4.2.8 NMAC – Rp, 13.4.2.8 NMAC, 04/01/2025]

13.4.2.9 LICENSING REQUIREMENTS FOR INDIVIDUALS: The superintendent will issue, renew and continue resident licenses for individual insurance producers to transact the kinds of insurance as set forth in 13.4.2.8 NMAC.

A. General requirements.

(1) An applicant shall be at least 18 years of age;

(2) an applicant shall file an application electronically or as otherwise specified by the superintendent;

(3) an applicant shall pay the fees required by Section 59A-6-1 NMSA 1978 as well as providing any additional bond, liability coverage or letter of credit that may be required by the license applied for;

(4) an applicant shall not have committed an act that is a ground for license denial, suspension or revocation under the Insurance Code; and

(5) an applicant shall have passed the examination required for each line of authority for which the license is sought, if examination is required by 13.4.2.11 NMAC.

B. Application form.

(1) The application form may require the following information about the applicant:

(a) proof of the applicant's identity;

(b) name, date of birth, social security number and residence and business address;

(c) personal history;

(d) business experience, including experience, special training or education in the kind of business to be transacted under the license applied for;

(e) previous licensing information, including:

(i) whether the applicant was ever previously licensed to transact insurance in this state or elsewhere;

(ii) whether any license was ever refused, suspended or revoked;

(iii) whether any insurer claims that the applicant is indebted to it, and if so, the details of the claim; and

(iv) whether the applicant has ever had an insurance agency contract or appointment canceled and, if so, the facts of the cancellation;

(f) type of license applied for and kinds of insurance or transactions to be covered thereby;

(g) if the applicant will be adjusting workers' compensation claims, then an in-state physical address for the business entity;

(h) the NAIC number and name of the company holding a New Mexico certificate of authority that is sponsoring the applicant, if applicable;

(i) additional information relating to a particular type of license; and

(j) such other pertinent information and matters as the superintendent may reasonably require.

(2) The superintendent may require any application to be in the applicant's handwriting and under the applicant's oath.

C. Approval. Before approving a license application and issuing a license the superintendent shall confirm that:

(1) all of the applicant's answers to the questions on the application are complete, truthful and satisfactory, including acknowledgment and explanation of any prior criminal charges;

(2) the applicant does not currently hold an active New Mexico resident or nonresident license or an active resident license in another state;

(3) the applicant has provided at least five years of employment history without gaps in the employment record;

(4) the applicant has provided an in-state residential or business address (a post office box does not satisfy this requirement);

(5) the applicant's fingerprints have been submitted for purposes of a state and federal background check, and

(a) pursuant to 18 U.S.C. Section 1033, no individual who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a resident producer, unless the person has the written consent of the superintendent;

(b) pursuant to the Criminal Offender Employment Act found at Section 28-2-1 et seq. NMSA 1978, any prior criminal record shall be considered in connection with application for any license under this article; and

(c) if the results of the background check have not been received or indicate a need for further investigation, the application will not be approved pending further review;

(6) the applicant has satisfied both the general and specific requirements and has provided any additional information necessary for the type of license requested or as required by the superintendent based the initial application answers;

(7) the applicant shall not use or intend to use the license solely to write insurance on the applicant's own life for the purpose of evading in spirit or intent the anti-rebate or anti-discrimination laws relating to insurance;

(8) if the applicant is a citizen of a foreign

county, then the application shall include proof that the applicant is eligible to reside and work in the United States; and

(9) the applicant has passed any required examination based on the type of license requested, as set forth in 13.4.2.11 NMAC.

D. Prohibitions. Pursuant to Section 59A-12-11 NMSA 1978, the superintendent shall not license as an insurance producer or permit any such license to continue if the superintendent finds that an applicant for license intends to offer, give or sell stock or other ownership or participating interest in the agency or brokerage as inducement to or in connection with purchase of insurance or that the licensee has previously done so.

E. Contents of license. The contents of the license shall be consistent with the requirements set forth in Section 59A-11-9 NMSA 1978.

F. Special licensing requirements.

(1) Limited line credit insurance license applicants shall include evidence that the insurer will provide a program of instruction to include selling, soliciting and negotiating credit insurance that has been approved by the superintendent.

(2) Variable life and variable annuity or fraternal variable life and variable annuity license applications shall be deferred and reviewed manually by the superintendent. The applicant's FINRA and CRD numbers shall be supplied.

(3) Applicants shall apply for or actively hold a producer license for the life line of authority within the requested license class as follows:

(a) A variable life or a variable annuity producer license requires a life producer license.

(b) A variable life or a variable annuity consultant license requires a life insurance consultant license.

(c) A fraternal variable life or a variable annuity producer licenses requires a fraternal life producer license.

(d) A temporary variable life or a variable annuity producer license requires a temporary producer license.

(e) A viatical variable life or a variable annuity broker license requires a viatical life broker license.

(4) Surplus lines broker applicants shall actively hold both current property and casualty producer licenses prior to applying for a surplus lines broker license.

[13.4.2.9 NMAC – Rp, 13.4.2.9 NMAC, 04/01/2025]

13.4.2.10 LICENSING REQUIREMENTS FOR BUSINESS ENTITIES:

A. General requirements. A business entity acting as an insurance producer is required to obtain an insurance producer license pursuant to Sections 59A-11-3 NMSA 1978 and 59A-12-15 NMSA

(1) When licensing of a business entity is required, the application shall be filed by the business entity.

(2) The application shall be submitted electronically using the uniform business entity application or as otherwise specified by the superintendent.

(3) The business entity shall specify the business type as one of the following legal business types:

(a) partnership;

(b) limited liability company (LLC);

(c) limited liability partnership (LLP); or

(d) corporation.

A sole proprietorship may not apply for a business insurance producer license.

(4) The application shall be accompanied by payment of fees, as follows:

(a) all fees required pursuant to Section 59A-6-1 NMSA 1978;

(b) any bond or letter of credit required for the license applied for; and

(c) an additional license application filing fee for each individual in excess of one who is to exercise the license powers of the business entity, if not a general partner therein.

(5) The application shall be signed on behalf of the applicant by an authorized partner or corporate officer, under oath if required by the superintendent.

(6) If the business is a firm, then each individual who is not a bona fide general partner and who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

(7) If the business is a corporation, then each individual, whether or not an officer, director, stockholder or in other relationship to the corporation, who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

(8) If the business is a partnership, then each individual who is not a general partner and who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

B. Application form. The application form may require information about the business entity as follows:

(1) the name, state of residence, proof of identity, business record, reputation and experience of each partner, officer, member of the board of directors and controlling stockholder of the business entity, and any additional information required of an individual applicant for a producer license as the superintendent deems necessary;

(2) evidence satisfactory to the superintendent that

transaction of the business proposed to be transacted under the requested license is within the powers of the business entity as set forth in the entity's articles of incorporation, charter, bylaws, partnership, operating agreement or other governing documents;

(3) at least one individual is specified as the designated responsible licensed producer (DRLP) who is actively licensed in this state as either a resident or nonresident producer for each of the lines of authority applied for by the business entity;

(a) The DRLP(s) designated by the business entity shall cumulatively be licensed for all lines of authority of the business entity; except that

(b) business entities of the following types seeking a producer license are not required to designate a DRLP: portable electronics, rental car insurance producers and third party administrators; and

(4) such further information concerning the applicant, appointment of partners, corporate officers, directors and stockholders as may be requested by the superintendent.

C. Approval. The superintendent shall review the application and confirm that:

(1) all answers to the questions on the application are complete, truthful and satisfactory;

(2) the applicant does not already hold an active resident or nonresident license in New Mexico or an active resident license in another state;

(3) the business entity has paid the fees set forth in Section 59A-6-1 NMSA 1978, as well as providing any additional bond, liability coverage or letter of credit that may be required by the type or types of license applied for;

(4) the business entity application lists at least one individual as an owner, officer, partner or director;

(5) the business entity has designated a licensed insurance producer responsible for the business entity's compliance with the insurance laws of this state for every line of authority listed in the application;

(6) the application sets forth the names of all the members, officers and directors of the business entity and the names of each individual who is to exercise the powers conferred by the license upon the business entity;

(7) the business entity license application uses the entity's legal name, unless an assumed name has been previously approved in writing by the superintendent; and

(8) at least one licensed insurance producer who is to exercise license powers is affiliated by submission of an application, and the application for affiliation was submitted with payment as required in Section 59A-6-1 NMSA 1978.

D. Prohibitions, Contents of license, Special licensing requirements. The provisions of Subsections D, E and F of 13.4.2.9 NMAC apply also to business entities seeking a producer license.

[13.4.2.10 NMAC – Rp, 13.4.2.10 NMAC, 04/01/2025]

13.4.2.11 EXAMINATION OF APPLICANTS:

A. Applications requiring examination.

(1) Individuals applying for the following types of resident licenses shall take and pass the examination required for issuance of the license by the superintendent:

(a) insurance producer – producer examination;

(b) independent, public or staff adjuster – adjuster examination;

(c) insurance consultant – producer or consultant examination;

(d) viatical broker – producer examination;

(e) surplus lines broker – surplus lines broker examination; and

(f) title insurance producer – title insurance producer examination.

(2) Separate exams may be required for different lines of insurance or license types and may be administered at different times and locations.

B. Examination exemptions.

(1) Pursuant to Section 59A-11-10 NMSA 1978, reexamination is not required for renewal or continuance of current resident licenses unless ordered by the superintendent.

(2) Reexamination is not required for resident applicants who have been licensed in this state within the five years prior to the date of the new application and who seek to be relicensed for the same line or lines of insurance. This exemption does not apply if the previous license was suspended or revoked, if continuation of the license was refused by the superintendent or if the applicant did not previously take and pass an exam in this state.

(3) Examination is not required for:

(a) Applicants seeking a limited lines license in order to transact credit, travel or portable electronics insurance;

(b) Applicants seeking to be licensed as a life and annuity or accident and health insurance producer who hold the Chartered Life Underwriter (C.L.U.) designation by the American College of Life Underwriters;

(c) Applicants seeking to be licensed as a property or casualty insurance producer who hold the designation of Chartered Property and Casualty Underwriter (C.P.C.U.) by the American Institute of Property and Casualty Underwriters;

(d) Applicants seeking a rental car endorsement to transact rental car

insurance under the supervision of a rental car producer that has previously provided a training course that has been submitted to and approved by the superintendent pursuant to Subsection D of Section 59A-32A-5 NMSA 1978;

(e) Applicants for a temporary license; or

(f) Applicants for registration as a motor club representative.

(4) Examination is not required for applicant who have taken and passed a similar examination and received a license for the same line or lines of authority in a state in which the reciprocal provisions of Section 59A-5-33 NMSA 1978 apply and:

(a) the license in the other state is current, or

(b) the application is received within 90 days after of cancellation of the previous license. If the license has been canceled, then the following is required:

(i) a certification from the reciprocal state that at the time of cancellation the applicant was in good standing in that state; or

(ii) records maintained by the NAIC indicate that the insurance producer is or was licensed in good standing for the line of authority requested.

(5) Examination is not required for an applicant currently licensed as an insurance producer in another state who moves to this state and applies to become a resident insurance producer within 90 days of establishing legal residence. For such applicants, the examination requirement is waived as to licensure for any line of authority previously held in the prior state, unless otherwise determined by the superintendent.

(6) Examination is not required for an applicant for a license who is a transportation ticket selling agent of a common carrier and who acts under the license only in reference to the issuance of health and accident insurance policies, or insurance on personal effects while being carried as baggage, in connection with the transportation provided by the transportation ticket.

C. Conduct of examinations.

(1) Applicants shall submit a nonrefundable examination fee as set forth in Section 59A-6-1 NMSA 1978.

(2) The superintendent may designate an outside testing service to register applicants and collect examination fees, develop and administer exams, and score and report exam results subject to these requirements:

(a) The activities of the testing service shall be supervised by the superintendent.

(b) Any examination that is developed by the testing service or other outside source shall be reviewed and approved by the superintendent before it is administered. Each examination question and answer shall be verified and approved as to correctness, relevance, content and other factors.

(3) Each examination, as a whole, shall provide a comprehensive test of the applicant's knowledge necessary for the type of license applied for, the duties and responsibilities of the licensee and the insurance laws and regulations of this state.

(4) All examinations shall be conducted in an appropriate setting.

(5) Each examination shall be offered to applicants for a particular license type at least once each month at places within this state designated by the superintendent.

(6) Registration for each offering of the required examinations shall be available online or as otherwise directed by the superintendent.

(7) All examinations shall be available in the Spanish language upon request.

(8) Examination site accommodations shall be available upon request.

D. Examination scoring; pass and fail.

(1) Each examination shall require examinees to answer questions.

(2) The examination shall be scored for all examinees in a fair, impartial and non-discriminatory manner using a consistent scoring process.

(3) An examinee shall achieve a minimum score of seventy percent in order to pass the examination.

(4) An applicant who registers to take an examination but fails to appear as scheduled or fails to pass the examination may reapply and shall resubmit all required fees and forms before being scheduled for another examination.

(5) Any applicant who fails to pass an examination may retake the examination at any subsequent scheduled examination date. However, an applicant who has taken and failed to pass the same examination four times shall not be entitled to take another examination until at least six months after the date of the last examination failed.

E. Examination preparation.

(1) The superintendent may prepare and make available a manual showing the general type and scope of all required examinations.

(2) Information and access to manuals will be provided through the OSI website or as otherwise determined by the superintendent.

[13.4.2.11 NMAC – Rp, 13.4.2.11 NMAC, 04/01/2025]

13.4.2.12 COMMISSIONS AND COMPENSATION:

A. Payment of commissions and compensation.

(1) An insurance company or insurance producer shall not pay to a person, nor

shall a person accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state unless that person is licensed as required by this state.

(2) Renewal and other deferred commissions may be subsequently paid to a person for selling, soliciting or negotiating insurance in this state if the person was licensed as required at the time of the transaction.

(3) An insurer or insurance producer shall not pay or assign commissions, service fees or other valuable consideration derived from insurance of risks in this state to an individual or business entity who is not licensed to sell, solicit or negotiate insurance in this state.

B. Sharing of commissions and compensation.

(1) Sharing in commissions and compensation between licensees shall be infrequent and shall not be used to avoid appointment of producers by insurers.

(2) A licensee shall not receive a share in commissions or compensation unless the licensee is licensed as to the type of transaction or kind of insurance placed.

(3) An insurance producer shall share commissions or compensation for or on account of the solicitation or negotiation of insurance on individuals, property or risks in this state only with a duly licensed producer appointed by the insurer with which the insurance was placed, or with a duly licensed broker.

(4) The purchase price of a business entity may include ongoing payments or partial payments of accruing commissions to or on behalf of a former owner, whether or not the former owner maintains a current insurance producer license.

(5) Payment of commissions, compensation or other valuable consideration may be made to the personal representative, trust or beneficiary of a deceased insurance producer or broker, or to the deceased producer or broker's heirs or devisees if the estate has been distributed and the decedent would otherwise be entitled to the payment.

C. Disclosure of compensation.

When any insurance producer or any affiliate of the insurance producer receives any compensation from a customer for the placement of insurance or represents the customer with respect to placement of insurance, that producer or affiliate shall comply with the disclosure requirements set forth in Section 59A-12-29 NMSA 1978.
[13.4.2.12 NMAC – Rp, 13.4.2.12 NMAC, 04/01/2025]

13.4.2.13 LICENSING OF TITLE INSURANCE PRODUCERS, ESCROW OFFICERS AND TITLE ABSTRACT PLANTS:

A. License required.

(1) Title agents and escrow officers shall be licensed as title insurance producers. In addition to the requirements in this section, they shall also comply with additional requirements set forth in Section 59A-30-1 et seq. NMSA 1978 and in 13.14.1 through 13.14.19 NMAC.

(2) An applicant for a title insurance producer license shall comply with the provisions of 13.4.2.9 NMAC for individual producers or 13.4.2.10 NMAC for business entities.

(3) All applications for a title insurance producer license shall contain a statement that the applicant owns, operates, controls or is affiliated with a licensed title abstract plant or is employed by an individual or entity that does.

(4) Applications shall specify only the county or counties that are supported by the title abstract plant and the title producer license shall permit the licensee to issue policies only on property located in the county or counties for which the licensee has the necessary title abstract plant.

B. Title abstract plant defined. The title abstract plant shall consist of a set of records in which an entry has been made for every document or matter that under the law imparts constructive notice affecting title to, interest in or encumbrances on real property, and that has been filed or recorded in the county for which the title abstract plant is maintained.

(1) The records shall cover a period of 20 years immediately prior to the date of application and shall consist of:

(a) an index or indices in which notations of or references to any documents that describe the property affected are posted, entered or otherwise included, sorted and filed according to the property described; or copies or briefs of all documents that describe the property affected which are sorted and filed according to the property described; and

(b) an index or indices in which all other documents are posted, entered or otherwise included, sorted and filed according to the name or names of the party or parties whose title to real property or any interest or encumbrance is affected.

(2) A title insurance producer license permits the licensee to issue title insurance only on property located in the county or counties for which the licensee has the necessary licensed title abstract plant.

(3) The title insurance producer shall be responsible for maintaining and updating the records of the title abstract plant within 30 days of the courthouse land update schedule.

C. Plant inspections. The title abstract plant shall be subject to inspection by the superintendent. During an inspection, the superintendent may inspect to ascertain that the plant's records are current and that all persons engaged in the business of transacting title insurance are properly licensed and have been appointed by all insurers for whom they transact business.
[13.4.2.13 NMAC – Rp, 13.4.2.13 NMAC, 04/01/2025]

13.4.2.14 LICENSING OF LIMITED LINES TRAVEL INSURANCE PRODUCERS:

A. License required.

(1) All applicants for travel insurance producer licenses shall comply with the provisions of 13.4.2.9 NMAC for individual producers or 13.4.2.10 NMAC for business entities.

(2) Upon licensure, the travel insurance producer shall create a register with information about each travel retailer that offers travel insurance on the producer's behalf as set forth in Paragraph (2) of Subsection B of Section 59A-12-18.1 NMSA 1978. The register shall be updated at least annually and made available to the superintendent upon request.

(3) The travel insurance producer shall select a licensed individual insurance producer employee as its designated responsible producer who shall be responsible for the travel insurance producer's compliance with the travel insurance laws and rules of this state.

(4) The designated responsible producer, president, secretary, treasurer and any other officers or persons who direct or control the travel insurance producer's operations shall comply with the fingerprinting and criminal background check requirements of Paragraphs (3) and (4) of Subsection B of Section 59A-12-12 NMSA 1978.

(5) The travel insurance producer shall pay all applicable fees set forth in Section 59A-6-1 NMSA 1978.

(6) The travel insurance producer shall require training of employees and representatives of the retailer as set forth in Paragraph (6) of Subsection B of Section 59A-12-18.1 NMSA 1978.

B. Travel insurance producer and travel retailer responsibilities.

(1) A travel insurance producer shall be responsible for acts of the travel retailer and shall reasonably ensure that the travel retailer complies with the requirements set forth in Section 59A-12-18.1 NMSA 1978.

(2) A travel retailer may offer travel insurance under the license of a travel insurance producer only if:

(a) the travel insurance producer or travel retailer provides to prospective purchasers of travel insurance the items required by Subsection C of Section 59A-12-18.1 NMSA 1978; and

(b) no travel retailer employee or authorized representative who is not licensed as an insurance producer shall provide certain services as set forth in Subsection D of Section 59A-12-18.1 NMSA 1978.

(3) A travel retailer's employees and authorized representatives whose insurance-related activities are limited to the offering and disseminating of travel insurance on behalf and under the direction of a licensed travel insurance producer may receive compensation for those activities.

(4) Travel insurance may be placed as an individual, group or master policy.

C. Travel insurance vending machines.

(1) A licensed insurance producer may solicit for and issue personal travel accident insurance policies of an authorized insurer by means of mechanical vending machines supervised by the insurance producer and placed at airports and other places of convenience to the traveling public if the superintendent finds that:

(a) the travel insurance policy provides reasonable coverage and benefits and is suitable for sale and issuance by vending machine and that use of such a machine in a proposed location would be of material convenience to the public;

(b) the type of machine proposed to be used is reasonably suitable for the purpose;

(c) reasonable means are provided for informing prospective purchasers of policy coverages and restrictions;

(d) reasonable means are provided for the refund of money inserted in defective machines and which insurance so paid for is not received; and

(e) the cost of maintaining such a machine at a particular location is reasonable.

(2) For each travel insurance vending machine the superintendent shall issue a special vending machine license.

(a) The license shall state the name and address of the insurer and insurance producer, the name of the policy to be sold and the serial number, type and operating location of the machine.

(b) The license shall be subject to biennial continuation and to expiration, suspension or revocation coincidental with the license of the insurance producer.

(c) The superintendent shall revoke the license for any vending machine if the superintendent finds that license qualifications no longer exist.

(d) Proof of existence of a vending machine license shall be displayed on or about each machine in use in the manner that the superintendent reasonably requires.

[13.4.2.14 NMAC – Rp, 13.4.2.14 NMAC, 04/01/2025]

13.4.2.15 LICENSING OF LIMITED LINES RENTAL CAR INSURANCE PRODUCERS AND ENDORSEES:

A. License required.

(1) No rental car company nor its officers, director, employees or agents shall offer, sell, bind, effect, solicit or negotiate the purchase of rental car insurance unless that company is licensed as an insurance producer pursuant to Section 59A-32A-1 et seq. NMSA 1978.

(2) A rental car company may only act on behalf of an insurer that is authorized to write such insurance in this state.

(3) Rental car

insurance may not be offered, except in connection with and incidental to a rental agreement.

(4) Neither a rental car insurance producer nor an endorsee shall represent itself as qualified or licensed as an insurance producer beyond the scope of the limitations set forth in Subsection B of Section 59A-32A-7 NMSA 1978.

(5) A rental car company may not compensate any person, including any of its employees, based solely on placement of rental car insurance.

B. Rental car insurance producer license requirements.

(1) All applicants for rental car insurance producer licenses shall comply with the provisions of 13.4.2.10 NMAC for business entities.

(2) The application shall include a list of all the locations within the state where the rental car insurance producer intends to offer, sell, bind, effect, solicit or negotiate rental car insurance.

(3) The rental car insurance producer license application shall include:

(a) a certificate filed by an insurer indicating that the insurer has reviewed the applicant's training program and believes that it satisfies the requirements of Subsection D of 59A-32A-5 NMSA 1978; and

(b) the insurer intends to appoint the applicant to act as its rental car insurance producer if a license is granted to the applicant by the superintendent.

(4) A rental car insurance producer shall be responsible for establishing a training program for its employees that satisfies the requirements of Subsection D of Section 59A-32A-5 NMSA 1978. The program shall be submitted to and approved by the superintendent prior to its use.

(5) At the time of application, a rental car insurance producer license applicant shall establish, in a format prescribed by the superintendent, a list of its endorsees that also identifies a manager or supervisor for each of the applicant's locations. The list shall be updated quarterly and retained for three years by the applicant. The list shall be provided to the superintendent for inspection upon request.

(6) A rental car insurance producer shall ensure that the actions of its endorsees are properly supervised at all of its locations and shall be held responsible for the actions of its endorsees.

C. Rental car insurance endorsee requirements.

(1) An endorsee shall be at least 18 years of age and an employee of a rental car insurance producer.

(2) An endorsee shall complete the rental car insurance producer's approved training program prior to transacting any rental car insurance.

(3) An endorsee shall act on behalf of the rental car insurance producer under the direct supervision of the manager or supervisor at the location where employed.

(4) An endorsee's authorization expires upon termination of employment with the rental car insurance producer.

(5) The rental car insurance endorsee may offer, sell, bind, effect, solicit or negotiate rental car insurance on behalf of the rental car insurance producer subject to the above provisions and additional provisions set forth in Section 59A-32A-1 et seq. NMSA 1978.
[13.4.2.15 NMAC – Rp, 13.4.2.15 NMAC, 04/01/2025]

13.4.2.16 REGISTRATION OF MOTOR CLUB REPRESENTATIVES:

A. Registration required. No individual shall represent a motor club in this state unless that person is registered with the superintendent by a motor club holding a current certificate of authority issued pursuant to Section 59A-5-1 NMSA 1978.

B. Qualifications for registration. An applicant for registration as a motor club representative shall, at a minimum:

(1) be at least 18 years of age;

(2) be of good personal and business reputation;

(3) not previously have had registration refused or revoked;

(4) be suitable and competent to act as such a representative; and

(5) intend in good faith to act and hold him- or herself out as such a representative.

C. Procedures for registration.

(1) Applications for motor club representative registrations are handled in the same manner as applications for casualty insurance producer licenses, except that no examination is required.

(2) Continuations, terminations, denials, suspensions and cancellations of motor club representative registrations are handled in the same manner as those for insurance producer licenses as set forth in 13.4.2.27 and 13.4.2.28 NMAC.

(3) Fees for motor club representative registrations and continuations are as set forth in Section 59A-6-1 et seq. NMSA 1978.
[13.4.2.16 NMAC – Rp, 13.4.2.16 NMAC, 04/01/2025]

13.4.2.17 [RESERVED]
[13.2.4.17 NMAC – N, 4/2/2018; Repealed, 04/01/2025

13.4.2.18 LICENSING OF PREPAID DENTAL PLAN MEMBERSHIP PRODUCERS:

A. License and appointment required. No person shall solicit membership in a prepaid dental plan unless that person has been licensed by the superintendent as a health insurance producer and appointed by the prepaid dental plan organization to act in this state on the plan's behalf, pursuant to Section 59A-48-14 NMSA 1978. These

persons shall comply with insurance producer licensing requirements.

B. Qualifications for licensing. Individuals shall be licensed as producers as described in 13.4.2.9 NMAC and business entities shall be licensed as producers as described in 13.4.2.10 NMAC. Individual licensees shall comply with the examination and continuing education requirements for health insurance producers.

C. Fees and renewals. Both individual producers and business entities that are licensed as producers and acting on behalf of a prepaid dental plan shall comply with the fee and renewal schedules set forth in Section 59A-6-1 NMSA 1978.

[13.4.2.18 NMAC – Rp, 13.4.2.18 NMAC, 04/01/2025]

13.4.2.19 LICENSING OF PREARRANGED FUNERAL PLAN PRODUCERS:

A. License required. Any person engaged in the sale of prearranged funeral plans shall be licensed by the superintendent as a life insurance producer. Individuals shall be licensed as producers as described in 13.4.2.9 NMAC and business entities shall be licensed as producers as described in 13.4.2.10 NMAC. The licensee may have no association with the funeral service provider pursuant to Section 59A-49-5 NMSA 1978.

B. Handling of funds. Funds received in connection with sale of a prearranged funeral plan shall be deposited and withdrawn from a trustee subject to the fiduciary duties set forth in Subsection B of 13.4.2.23 NMAC. Strict controls shall be placed over sale of funeral plans and management of collected funds due to the longer anticipated time between the sale of a plan and delivery of the services. The trustee's records and accounting of funds shall be subject to review by the superintendent upon reasonable request.

[13.4.2.19 NMAC – Rp, 13.4.2.19 NMAC, 04/01/2025]

13.4.2.20 LICENSING OF FRATERNAL BENEFIT SOCIETY PRODUCERS:

A. License required. Individuals shall be licensed as producers as described in 13.4.2.9 NMAC and business entities shall be licensed as producers as described in 13.4.2.10 NMAC, except as follows:

(1) Fraternal benefit society producers are not required to fulfill the continuing education requirements set forth in 13.4.7 NMAC.

(2) Fraternal Benefit producers shall actively hold a producer license with the line of authority within the requested license class as follows;

(a) A fraternal accident and health or sickness producer license requires an accident and health or sickness producer license.

(b) A fraternal life or a fraternal variable annuity producer license requires a life insurance producer license.

(c) A fraternal life or an annuity producer licenses requires a life insurance producer license.

B. Continuation, suspension, revocation and termination of licenses. General provisions pertaining to the continuation, suspension, revocation and termination of producer licenses shall also apply to licenses issued to fraternal benefit society producers as set forth in 13.4.2.27 and 13.4.2.28 NMAC.

[13.4.2.20 NMAC – Rp, 13.4.2.20 NMAC, 04/01/2025]

13.4.2.21 LICENSING OF PORTABLE ELECTRONICS INSURANCE VENDORS:

A. License required. A vendor of portable electronics shall not sell or offer insurance covering portable electronics unless licensed as a limited lines producer in accordance with Subsection B of Section 59A-12-18 NMSA.

(1) A vendor's application shall identify an individual employee or officer of the vendor's organization as the compliance officer with respect to requirements of the Portable Electronics Insurance Act, as set forth in Section 59A-60-1 et seq. NMSA 1978. The application shall also provide the address of the vendor's home office.

(2) Any employee or authorized representative of a licensed vendor may offer and sell insurance covering portable electronics to eligible customers at any location at which the vendor sells portable electronics without obtaining a separate license from the superintendent. These employees and representatives may not represent themselves as personally licensed as a limited lines producer.

(3) The insurer issuing the insurance or its designee shall be responsible for supervising the activities of the vendor's employees and administration of the insurance program.

(a) The insurer shall develop and deliver a training program for the vendor's employees or authorized representatives who offer or sell insurance covering portable electronics.

(b) The training program shall comply with all of the requirements set forth in Paragraph (2) of Subsection D of Section 59A-60-4 NMSA 1978.

(4) A vendor shall maintain a list of its locations that are authorized to sell portable electronics insurance in this state. The list shall be made available to the superintendent upon reasonable notice and request.

(5) Compensation of employees who offer or sell portable electronics insurance on behalf of the vendor shall be in accordance with Section C of Section 59A-60-4 NMSA 1978.

B. Offer and sale of insurance. A licensed vendor shall sell or offer portable electronics insurance only as incidental to the purchase or lease of portable electronics or related services sold or offered by the vendor. A licensed vendor shall provide all required

insurance-related information to customers and prospective customers as set forth in Subsection A of Section 59A-60-4 NMSA 1978.

C. Handling of payments and funds. Payments for portable electronics insurance and handling of funds shall be consistence with the requirements of Subsection C of Section 59A-60-4 NMSA 1978. Funds received by a vendor for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer as set forth in Subsection B of 13.4.2.23 NMAC.

D. Penalties, fines and actions against the license. The superintendent may impose fines or suspend or revoke a vendor's right to transact portable electronics insurance at specific locations where a violation has occurred or may suspend the rights of an individual employee or representative for violation of the Portable Electronics Insurance Act. [13.4.2.21 NMAC – Rp, 13.4.2.21 NMAC, 04/01/2025]

13.4.2.22 LICENSING OF REINSURANCE INTERMEDIARIES:

A. License required.

(1) With respect to the Reinsurance Intermediary Law set forth at Section 59A-12D-1 et seq. NMSA 1978 and this section, "producer" means a licensed producer, broker or reinsurance intermediary. A reinsurance intermediary is as defined in Subsection E of Section 59A-12D-2 NMSA 1978.

(2) Any person acting as either a reinsurance intermediary-broker or as a reinsurance intermediary-manager in this state and either domiciled or with an office located directly or indirectly in this state shall be licensed as a producer in this state.

(a) Typically, an intermediary-broker represents the insurer who is seeking to cede risk to a reinsurer and solicits offers on behalf of the ceding insurer.

(b) Typically, an intermediary-manager acts on behalf of and with authority to bind the reinsurer.

(c) The intermediary's knowledge is imputed to the principal, which may result in adverse consequences to the principal in resolving a dispute.

(3) Any person acting as either a reinsurance intermediary-broker or intermediary-manager in this state and with an office located in another state may be licensed as a producer in that state, if that state's licensing law is substantially similar to the Reinsurance Intermediary Law set forth at Subsection D of Section 59A-12D-1 et seq. NMSA 1978. Otherwise, that person shall be licensed as a producer in this state.

B. Licensing requirements.

(1) A reinsurance intermediary must file and maintain either a fidelity bond or an errors and omissions policy for the protection of the reinsurer. The fidelity bond or the errors and omissions policy must be issued by an admitted insurer or an eligible surplus lines insurer, be in an amount or at an aggregate limit equal to at least $1,000,000 for the benefit of each reinsurer with whom the reinsurance intermediary contracts, and must provide that the superintendent be notified prior to its cancellation or nonrenewal.

(2) The superintendent may issue a reinsurance producer license to an individual or a business entity as follows:

(a) to an individual who has complied with the producer licensing requirements described in 13.4.2.9 NMAC or to a business entity that has complied with the producer licensing requirements described in 13.4.2.10 NMAC;

(b) that has complied with the requirements of the Reinsurance Intermediary Law set forth in Section 59A-12D-1 et seq. NMSA 1978; and

(c) if a business entity, that has named in its application its members, officers, and designated employees who shall act on behalf of the reinsurance intermediary in this state.

C. Denial, suspension or revocation of license. The superintendent may refuse to issue, suspend or revoke a reinsurance intermediary's license in accordance with 13.4.2.27 and 13.4.2.28 NMAC. Furthermore, the superintendent may refuse, suspend or revoke a reinsurer's right to transact business in this state based on the acts of its reinsurance intermediaries done within the scope of their actual or apparent authority.

D. Exception from licensing. Attorneys holding a current license to practice law in this state are not required to be licensed as reinsurance producers when acting in their professional capacity.

E. Duties of a reinsurance intermediary.

(1) Required contract provisions between insurers or reinsurers and reinsurance intermediaries. A reinsurance intermediary may not transact reinsurance in this state except pursuant to a written contract detailing the responsibilities and agreement between the reinsurance intermediary and the principal.

(a) The contract shall be as set forth in Section 59A-23D-7 NMSA 1978 and shall be filed with the superintendent for approval at least thirty days in advance of its effective date.

(b) Duty of care and loyalty. The contract shall clearly set forth the reinsurance intermediary's duty to clearly communicate the terms of a proposed reinsurance agreement, to disclose facts and circumstances including material information pertaining to underlying risks that may reasonably be expected to impact the obligations of the insurer or reinsurer, to negotiate terms and conditions of a contract for reinsurance, to assist in memorializing the agreement and to maintain records.

(c) Program of reinsurance. Depending on the terms of the written contract, a reinsurance intermediary's duties may extend to developing a program of reinsurance on behalf of the insurer that includes modeling to estimate probabilities of potential loss outcomes, estimating costs of alternate programs, identifying a pool of potential reinsurers, presenting an information packet to reinsurers on behalf of the insurer, negotiating terms of a contract and assisting in drafting and execution of a contract for reinsurance.

(2) Fiduciary duty. A reinsurance intermediary may act as a conduit between the insurer and reinsurer, including for collection and transmission of premiums, communication of loss and claim information, and collection of funds from a reinsurer on behalf of the insurer. A reinsurance intermediary has a fiduciary duty with respect to any funds held in trust by or transmitted through the reinsurance intermediary by either the insurer or reinsurer.

(3) Record-keeping requirements. A reinsurance intermediary shall annually file with the reinsurer a statement of its financial condition as set forth in Subsection K of Section 59A-12D-7 NMSA 1978. The reinsurance intermediary shall be subject to semi-annual review and inspection of its operations by the reinsurer. A reinsurance intermediary shall maintain complete records of all contracts and transactions for a minimum of ten years following the expiration of each contract for reinsurance.

[13.4.2.22 NMAC – Rp, 13.4.2.22 NMAC, 04/01/2025]

13.4.2.23 LICENSING OF INSURANCE CONSULTANTS:

A. License required. No person shall examine or offer to examine in exchange for a fee an insurance policy, annuity, endowment contract or other insurance document in order to offer advice, counsel, a recommendation or other information as described in Subsection A of Section 59A-11A-1 NMSA 1978 unless licensed as an insurance consultant. Neither may a person offer such services through advertisements or any other means that indicate the person is in business for that purpose, unless licensed as an insurance consultant.

B. Qualifications.

(1) Individual applicants for an insurance consultant license shall apply as though for an individual producer's license as set forth in 13.4.2.9 NMAC.

(2) An applicant shall pay the examination application fee as set forth in Section 59A-6-1 NMSA 1978 and shall pass either the insurance producer license examination or the insurance consultant examination required by 13.4.2.11 NMAC.

(3) The applicant shall demonstrate competence and knowledge of insurance contracts and practices of the insurance industry in the lines of insurance for which the license is applied.

C. Limitations, exemptions and conflicts.

(1) A licensed insurance producer may offer customary advice without holding an insurance consultant license.

(2) A licensee shall not receive compensation as either a producer or as a broker if the licensee receives a fee as a consultant for the same transaction as the subject of the consulting service provided.

(3) An attorney or a public accountant licensed to practice in this state is exempt from the insurance consultant licensing requirement when acting within the scope of their practice.

D. Renewal of license. The insurance consultant license is subject to biennial renewal according to the schedule set forth in 13.4.2.26 NMAC, and to suspension or revocation as set forth in 13.4.2.27 NMAC.

E. Contracts and agreements; collection of consulting fees.

(1) An insurance consultant shall not enforce an agreement to provide advice, counsel or a recommendation in exchange for a fee unless a written agreement has been executed between the insurance consultant and the advisee.

(2) At a minimum, the written agreement shall:

(a) be signed by the advisee;

(b) be executed in duplicate, with one copy retained by the advisee;

(c) state the amount paid by the advisee for the service if payment is made in advance, or the amount to be paid if payment is due following delivery of the service;

(d) state the terms of payment agreed upon by the parties if payment is not due immediately upon delivery of the service;

(e) specify the documents to be reviewed by the insurance consultant, and a copy of those documents shall be attached to the agreement, if available;

(f) specify the services to be delivered by the insurance consultant and the format in which delivery shall be made to the advisee;

(g) state the date and method by which the services shall be delivered; and

(h) provide any other information required by the superintendent.

(3) At a minimum, the insurance consultant shall provide the following upon delivery of the agreed services:

(a) a signed statement specifying the advice, counsel, recommendation or information provided to the advisee;

(b) a receipt for the fee paid or a statement indicating the fee to be paid to the consultant.

F. Recordkeeping requirements.

(1) An insurance consultant shall maintain records consistent with good business practices and shall furnish records of business methods, policies and transactions of the licensee within 10 days of a request by the superintendent.

(2) An insurance consultant shall, upon a request by the superintendent, furnish both the standard written agreement form used to document an agreement between the insurance consultant and an advisee and examples of executed agreements that confirm the insurance consultant's business practices.

[13.4.2.23 NMAC – Rp, 13.4.2.23 NMAC, 04/01/2025]

13.4.2.24 LICENSING OF MANAGING GENERAL AGENTS:

A. License required.

(1) No person shall act as a managing general agent on behalf of any insurer with respect to risks located in this state unless licensed as a producer in this state.

(2) No person shall act as a managing general agent on behalf of an insurer domiciled in this state with respect to risks located outside this state unless licensed as a producer in this state.

(3) The superintendent may issue a producer license to an individual managing general agent or a business entity acting as a managing general agent as follows:

(a) to an individual who has complied with the producer licensing requirements described in 13.4.2.9 NMAC or to a business entity that has complied with the producer licensing requirements described in 13.4.2.10 NMAC; and

(b) that has complied with the requirements of the Managing General Agents Law as set forth at Section 59A-12B-1 et seq. NMSA 1978.

B. Examination and penalties.

(1) The superintendent may refuse to issue, suspend or revoke a managing general agent's license in accordance with 13.4.2.27 and 13.4.2.28 NMAC.

(2) Actions of a managing general agent are considered to be those of the insurer on whose behalf the managing general agent is acting.

(3) The superintendent may examine a managing general agent as if examining the insurer on whose behalf the managing general agent is acting.

(4) If the superintendent determines that a managing general agent, an insurer or another person has failed to comply with the requirements of the Managing General Agents Law as set forth at Section 59A-12B-1 et seq. NMSA 1978, the superintendent may impose any of the penalties set forth in Subsection A of Section 59A-12B-7 NMSA 1978 or any other penalties permitted under the Insurance Code.

C. Required contract provisions. A managing general agent shall not act on behalf of an insurer except as pursuant to a written contract detailing the responsibilities and agreement between the managing general agent and the insurer as set forth in Section 59A-23B-4 NMSA 1978. The contract between a managing general agent and an insurer shall not be assigned by a managing general agent.

D. Record-keeping requirements. A managing general agent shall maintain complete records of all contracts and transactions for a minimum of seven years following the expiration of each written agreement. The superintendent shall have access to the records for the purpose of examination, audit and inspection.

The insurer shall have access sufficient to permit the insurer to fulfill its contractual obligations to insured persons.

E. Duties of insurers. An insurer that has contracted with one or more managing general agents shall comply with the requirements as set forth in Section 59A-12B-5 NMSA 1978, including but not limited to those pertaining to inspection and oversight of the managing general agent's processes and records and those requiring specific notifications to the superintendent.

[13.4.2.24 NMAC – Rp, 13.4.2.24 NMAC, 04/01/2025]

13.4.2.25 OBTAINING A TEMPORARY INSURANCE PRODUCER LICENSE:

A. Necessity and duration of license. The superintendent may issue a temporary insurance producer license to an individual for a period not to exceed 180 days without requiring an examination if the superintendent determines that the temporary license is necessary for the servicing of an insurance business in the following situations:

(1) to the surviving spouse or court-appointed personal representative of a licensed individual insurance producer who dies or becomes mentally or physically disabled, in order to allow adequate time for the sale of the producer's insurance business, for the producer's recovery and return to the business or to provide for the training and licensing of new personnel to operate the insurance producer's business;

(2) to an individual who is a member or employee of a business entity upon the death or disability of an individual who is a DRLP with respect to the business entity;

(3) to the designee of a licensed insurance producer entering active service in the armed forces of the United States; or

(4) in any other circumstance in which the superintendent determines that the public interest will best be served by issuance of the license.

B. Limitations.

(1) An applicant will not be issued a temporary license unless supervised by a suitable sponsor who is a licensed insurance producer or by an insurer who assumes responsibility for all acts of the temporary licensee.

(2) The superintendent may impose other limitations on the authority of any temporary licensee to protect insureds and the public.

(3) The superintendent may revoke a temporary insurance producer license if the interest of insureds or the public are endangered.

(4) A temporary license shall not continue after the owner or personal representative disposes of the business.

C. Application granted. Upon application for a temporary insurance producer license, the insurer and the applicant may assume that the license will be issued in due course, effective as of the date the application was filed with the superintendent, unless the superintendent notifies the insurer to the contrary within 15 days after the date of application.

[13.4.2.25 NMAC – Rp, 13.4.2.25 NMAC, 04/01/2025]

13.4.2.26 OTHER DUTIES OF LICENSEES:

A. Place of business.

(1) A resident licensed insurance producer shall have and maintain a place of business within this state that is accessible to the public and where the licensee transacts business under the license.

(2) With the exception of title insurance producers, a licensee's place of business may be in the licensee's residence.

(3) A licensee shall inform the superintendent in the format prescribed by the superintendent of a change in the licensee's legal name or address within 20 days of the change. Failure to timely inform the superintendent of a change in legal name or address shall result in a penalty of $50 pursuant to Subsection G of Section 59A-12-17 NMSA 1978.

B. Fiduciary duties.

(1) All funds of others received by a licensee shall be held in a fiduciary capacity. A licensee who diverts or appropriates such funds for personal use or takes or secrets such funds with intent to embezzle without the consent of the person entitled to the funds is guilty of larceny by embezzlement.

(2) Subject to the terms of any agreement between a licensee and the licensee's principal or obligee, each licensee who does not make immediate remittance of funds to the insurer or other person entitled to them shall elect and follow one of the following methods:

(a) remit insurance charges or premiums collected (less applicable commissions, if any) and return premiums to the insurer or person entitled thereto within 15 days after receipt; or

(b) establish and maintain one or more fiduciary bank accounts separate from accounts holding personal, firm or corporate funds, and promptly deposit and retain therein all funds of others pending transmittal to the insurer or person thereto entitled.

(i) Funds belonging to more than one principal may be as deposited and held in the same account so long as the amount held for each principal is readily ascertainable from the records of the licensee.

(ii) The licensee may commingle with such fiduciary funds in a particular account such additional funds as the licensee deems prudent for advancing premiums, reserves for the payment of return commissions or for other contingencies arising in the business of receiving and transmitting premiums or return premiums.

(3) The licensee may commingle with the licensee's own funds those funds of a particular principal who has expressly waived the segregation requirement in writing and in advance.

(4) Permitted commingling of the funds of others with funds of the licensee shall not alter the fiduciary duties of the licensee as to the others' funds.

(5) When requirements for handling of funds contained in other sections are in conflict with the requirements contained in this section, then those other requirements shall prevail as follows:

(a) Third-party administrators shall handle funds and pay, adjust and settle claims pursuant to the requirements of Sections 59A-12A-9 through 59A-12A-11 NMSA 1978.

(b) Title insurance producers shall manage escrow and other funds held in trust pursuant to the requirements of Section 59A-12-22 NMSA 1978 and 13.14.4 NMAC.

(c) Payments received in connection with the sale of prearranged funeral plans shall be subject to additional controls and shall be handled as set forth in 13.4.2.19 NMAC.

(d) Funds received by rental car insurance producers for the purchase of rental car insurance are not required to be treated as fiduciary funds or held in separate accounts.

C. Recordkeeping requirements.

(1) The requirements contained in this section apply generally to all licensees. However, where these rules differ from the recordkeeping requirements that are applicable to specific types of insurance producers the insurance producer shall also comply with the duties imposed by other rules, where applicable.

(2) An insurance producer shall keep complete records of transactions made under the license in the insurance producer's place of business. For each insurance policy placed by or through the licensee, the record shall include:

(a) the names of the insurer and insured;

(b) the number and expiration date;

(c) the premium payable;

(d) the names of all other persons from whom business is accepted or to

whom commissions are promised or paid;

(e) all premiums collected; and

(f) additional information as the superintendent may require.

(3) The records shall be available for the superintendent's examination, and the superintendent may at any reasonable time require the licensee to furnish any information kept or required to be kept in such records.

(4) Records shall be maintained for the statutory duration.

(a) Records of each insurance policy shall be retained for a minimum of three years after the policy's expiration, unless a longer period is required.

(b) Records pertaining to title insurance policies shall be retained for a minimum of 15 years after the issuance of the title insurance policy pursuant to Section 59A-30-11 NMSA 1978.

(c) Complete records of reinsurance transactions shall be retained by reinsurance intermediaries for at least ten years after the expiration of each contract, pursuant to Section 59A-12D-5 NMSA 1978.

(d) A third-party administrator shall keep adequate books and records of all transactions between it, insurers and insured persons in its administrative office for the duration of its contractual duties and for five years thereafter, pursuant to Section 59A-12A-6 NMSA 1978.

(e) Licensees may be required to manage and retain additional records for a differing stated duration based on the provisions of the Insurance Code.

(5) Books and records shall be maintained in accordance with prudent standards of insurance record keeping.

D. Duty to report any administrative actions, and civil and criminal prosecution.

(1) A licensee shall report to the superintendent any administrative action taken against the licensee in any jurisdiction or by another governmental agency in this state within 30 days of the final disposition of the matter. The report shall include a copy of the order, consent to order or other relevant legal documents.

(2) A licensee shall report to the superintendent any criminal prosecution of the licensee taken in any jurisdiction within 30 days after the initial pretrial hearing date. The report shall include a copy of the initial complaint filed, any order resulting from the hearing and other relevant legal documents.

(3) A licensee shall report to the superintendent the filing and progress of any civil complaint filed against the licensee in any jurisdiction. The initial report shall include a copy of the complaint. Subsequent reports shall be filed as the case progresses, and the final report shall include the final order, if any, and any other relevant legal documents.

(4) Title insurance producers shall report to the superintendent in compliance with the requirements set forth in 13.14.4.12 NMAC.

E. Duty to report license cancellation. A licensee whose out-of-state resident or non-resident license is canceled through either the action or inaction of the licensee shall report the cancellation to the superintendent within 30 days.

F. Duty to report fraud.

(1) A licensed insurance professional that has a reasonable belief that an act of insurance fraud will be, is being or has been committed shall report to the superintendent pursuant to Section 59A-16C-6 NMSA 1978 and shall cooperate fully with any investigation conducted by the superintendent,

(2) Failure to comply with this duty to report actual of suspected fraud shall constitute grounds for the superintendent to impose an administrative penalty pursuant to Section 59A-1-18 NMSA 1978 in addition to any applicable suspension, revocation or denial of a license.

[13.4.2.26 NMAC – Rp, 13.4.2.26 NMAC, 04/01/2025]

13.4.2.27 CONTINUATION, TERMINATION AND REINSTATEMENT OF LICENSES:

A. Continuation of producer licenses. An insurance producer license is continuous, subject to payment of renewal fees as set forth in Section 59A-6-1 NMSA 1978 and completion and submission on or before the due date of the continuing education requirements described in 13.4.7 NMAC, unless the license is canceled, revoked, suspended or otherwise terminated.

(1) A licensed insurance producer who is unable to comply with license renewal requirements due to military service or other extenuating circumstance may request a waiver using forms available on the OSI website or as otherwise directed by the superintendent. An insurance producer in such circumstances may also request a waiver of an examination requirement or of a fine or sanction imposed for failure to comply with renewal procedures.

(2) For licenses issued to individuals:

(a) For licenses issued on or after July 1, 2017, biennial renewal fees shall be paid on or before the last day of the second occurrence of the individual's birth month following issuance of the license.

(b) For licenses issued before July 1, 2017, details pertaining to biennial continuation and renewal of licenses are available on the OSI website for renewals due on March 1, 2018. Thereafter, the license shall be renewed according to the biennial schedule implemented on July 1, 2017.

(c) Continuing education requirements shall be satisfied during the 24 months

immediately preceding the renewal date of the license. Additional information pertaining to continuing education requirements may be found in Section 13.4.7 NMAC.

(d) If the superintendent has reason to believe that the competence of any licensee or individual designated to exercise license powers is in question, the superintendent may require as a condition of continuation of the license or license powers that the licensee or individual take and pass the written examination that is required for new applicants for the same license.

(3) For licenses issued to business entities:

(a) Business entity licenses shall renew and continue on a biennial basis on March 1 of the biennial year except for those types of business entity licenses that renew and continue annually pursuant to Section 59A-6-1 NMSA 1978, which shall renew and continue on March 1 of every year.

(b) Business entity affiliations shall renew and continue on an annual basis on March 1 of every year, subject to payment of fees pursuant to Section 59A-6-1 NMSA 1978.

B. Termination of licenses.

(1) A license that is not continued by the licensee shall be deemed terminated at midnight on the last day of the licensee's birth month in the renewal year if an individual license and at midnight of March 1 in the renewal year if a business entity license. However, at the superintendent's discretion, a licensee's request for continuation received within 30 days after the due date may be granted if accompanied by a continuation fee equal to one-hundred-and-fifty percent of the fee otherwise required.

(2) Authorization to transact business in this state shall automatically terminate without notice as of the date and time of termination of a license.

(3) Any license issued to an individual shall terminate upon the death of the person.

(4) If a corporation ceases to exist, its business entity license shall be tendered to the superintendent with notice of the dissolution.

(5) If a change occurs only in the officers or in the name of a corporation, it may continue to transact insurance under the license until action is taken by the superintendent upon a new application, if:

(a) within 30 days of the change, the surviving officers of the corporation file an application on a form prescribed by the superintendent for registration of a change in the officers or the name of the corporation and pay the required fees; and

(b) the application for registration of the change in officers is signed by the secretary or corresponding officer of the corporation.

(6) If the membership of a partnership changes, the surviving or continuing partner or partners may continue to transact insurance business under the license issued to the predecessor partnership until action is taken by the superintendent upon a new application, if:

(a) within 30 days, the surviving partner or partners file an application on a form prescribed by the superintendent for registration of a change in membership and pay the required fee;

(b) at least one person who exercises the producer powers of the predecessor entity continues to exercise those powers of the surviving or continuing partnership; and

(c) the application for registration of the change in membership is signed by a general partner.

C. Reinstatement of licenses.

(1) An individual licensee who allows the license to lapse may, within 12 months following the due date of the required renewal fee and completion of continuing education credits, reinstate the license without the necessity of passing a written examination.

(2) A penalty of double the unpaid renewal fee shall be required for a renewal received after the due date.

(3) If the producer has failed to comply with continuing education requirements during a lapse, the producer shall complete all continuing education hours that would have been necessary to keep the license in compliance. [13.4.2.27 NMAC – Rp, 13.4.2.27 NMAC, 04/01/2025]

13.4.2.28 DENIAL, SUSPENSION, REVOCATION OR CANCELLATION OF LICENSES:

A. Effects of suspension. While a license is suspended, the licensee shall not engage in any transaction for which the license is required, other than receipt and remittance of premiums paid for insurance or other business that was transacted by the licensee while the license was active.

B. Reasons for probation, suspension, revocation or refusal to continue license.

(1) The superintendent may take necessary action based on information obtained via the NAIC attachment warehouse personal information capture system alerts or other appropriate mechanisms used to monitor actions against existing licensees.

(2) It shall be the duty of the superintendent to cancel a license if the superintendent is satisfied that:

(a) a licensee obtained the license by willful misrepresentation or fraud;

(b) a licensee obtained the license chiefly for the purpose of writing insurance on the licensee's own life, property or liability, or on the lives, property or liability of the licensee's associates;

(c) a licensee is not complying with all state and federal laws and regulations relating to insurance; or

(d) the interests of the insured or the public are not being properly served under the license.

(3) The superintendent may place on probation, suspend, revoke or refuse to issue or renew a license for any of the reasons set forth in in Section 59A-11-14 NMSA 1978.

(4) A business entity's license may be suspended, revoked or refused if the superintendent finds after hearing that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation, the violation was not reported to the superintendent and no corrective action was taken.

(5) A rental car insurance producer's license may be revoked or suspended following a hearing by the superintendent for a violation by the producer or the producer's endorsees of the Rental Car Insurance Limited Producer License Act set forth at Section 59A-32A-8 NMSA 1978. The superintendent may also impose penalties or suspend a transaction of insurance at specific rental locations where such a violation has occurred.

C. Suspension or revocation of or refusal to continue a license.

(1) If the superintendent suspends, revokes or refuses to continue a license, the superintendent shall notify the applicant in writing. The notice shall advise the applicant of the reason for the decision.

(2) Within 30 days of the date of issuance of the notice, the applicant may request a hearing in writing pursuant to Section 59A-4-15 NMSA 1978. The hearing shall be held within 90 days.

(3) The superintendent retains the authority to enforce the provisions of and impose any penalty or remedy authorized by the Insurance Code against any person who is under investigation for or charged with a violation of the Insurance Code even if the person's license has been surrendered or has lapsed by operation of law.

D. Administrative fines.

(1) In addition to, or in lieu of, any applicable suspension, revocation or denial of a license the superintendent may impose fees or administrative fines pursuant to Section 59A-1-18 NMSA 1978 or a specific section of the Insurance Code.

(2) The amount of the administrative fine shall be not less than $100 nor more than $500 unless a small or larger fine is set by a specific section of the Insurance Code.

(3) In the order imposing the fine, the superintendent shall specify the grounds therefor and the period, not to exceed 60 days, within which the licensee shall pay the fine.

(4) If at the end of the allowed payment period the licensee has not paid the fine in full, the license immediately shall be suspended or revoked, or its renewal denied, as the case may be, without further order.

E. Duration of and reinstatement following suspension or revocation of license.

(1) In the order suspending a license, the superintendent shall state the period of suspension, which shall not exceed one year.

(a) The period of suspension may be modified by the superintendent's further order.

(b) At the end of the suspension period the license shall be reinstated upon request of the licensee unless the superintendent finds that the cause or causes of the suspension still exist or are likely to recur. If the superintendent so finds, he shall forthwith revoke the license by further order.

(2) An applicant whose license has been administratively revoked or suspended shall contact the superintendent in order to request reinstatement of the license.

(3) A licensee whose license has been revoked or suspended for noncompliance with the Parental Responsibility Act shall become compliant and provide evidence of compliance to the superintendent before the license may be reinstated.

(4) The superintendent shall not relicense a former licensee whose license has been revoked or its continuation refused without evidence that the former licensee is otherwise qualified for the license and that the cause or causes of the prior revocation or refusal to continue no longer exists and will not recur.

[13.4.2.28 NMAC – Rp, 13.4.2.28 NMAC, 04/01/2025]

13.4.2.29 APPOINTMENTS AND CANCELLATION OF PRODUCER CONTRACTS:

A license itself does not create any authority, actual, apparent, or inherent in the licensee to represent or commit an insurer.

A. Appointment of insurance producers.

(1) An insurance producer shall not act as an insurance producer on behalf of an insurer unless the insurance producer becomes an appointed insurance producer of that insurer. An insurance producer who is not acting on behalf of an insurer is not required to become appointed.

(2) An insurer shall appoint a producer using the online electronic application or as otherwise directed by the superintendent.

(a) The appointment shall be filed within 15 days from the date that the agency agreement is executed or when the first insurance application is submitted by the insurance producer on behalf of the insurer.

(b) An insurer may appoint an insurance producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment.

(c) An insurer shall pay the filing appointment fee set forth in Paragraph (3) of Subsection E of Section 59A-6-1 NMSA 1978 for each insurance producer the insurer appoints, but may contract for reimbursement of the fee by agreement with the producer.

(3) In the event of a merger between two or more insurers, appointments of producers by any of the insurers absorbed by the merger will continue with the resulting insurer.

B. Continuation of appointment.

(1) Appointments of insurance producers shall be continuous subject to the insurer's payment of continuation fees as required by Section 59A-6-1 NMSA 1978 and filing of notice of continuation with the superintendent.

(2) Notice of continuation and payment of continuation fees shall be filed annually with the superintendent on or before March 1 of each year. The annual filing shall include the name, address and license number of each insurance producer appointed by the insurer to solicit or transact business in this state on the insurer's behalf.

C. Termination of appointment.

(1) Insurance producer appointments terminate automatically on April 30 of the year after issuance or continuation of appointment if the appointing insurer does not file a continuation of appointment.

(2) No insurer authorized to transact property or casualty insurance business in this state shall terminate a contract appointing an independent insurance producer without giving the insurance producer written notice of the termination, including the specific reason for such action, at least 180 days prior to the termination except as provided in Subsection C of Section 59A-11-13 NMSA 1978.

(3) No insurer shall terminate an appointment with a property or casualty insurance producer based on an adverse loss-ratio, as set forth in Subsection B of Section 59A-11-13 NMSA 1978.

(4) Notice of termination of appointment by an insurer shall be provided to the superintendent using the online form, or as otherwise directed by the superintendent, within 30 days following the effective date of the termination.

(a) If the reason for termination is one of the reasons for which the superintendent may cancel, suspend, revoke or refuse to issue a license as set forth in 13.4.2.27 and 13.4.2.28 NMAC, Subsection C of Section 59A-11-13 NMSA 1978 and Section 59A-11-14 NMSA 1978, or if the insurer has knowledge that the producer has been found by a court or regulatory agency to have engaged in any of the activities prohibited by 13.4.2.27 NMAC, the notice shall disclose it.

(b) The insurer has a continuing obligation to report to the superintendent should additional information become available following the initial notification.

(c) The insurer shall provide additional information about the reason for termination upon the superintendent's request.

(5) If the reason for the termination is one or more of the activities listed in 13.4.2.27 NMAC, the insurer shall provide a copy of the notice via certified mail to the insurance producer's last known address within 15 days following submission of the notice to the superintendent.

(6) The insurance producer may provide to the superintendent additional information in response to the notice filed by the insurer within 30 days; both the insurer's notice and the insurance producer's response shall be made a permanent part of the file retained by the superintendent.

(7) Any documents and materials related to termination or cancellation of an insurance producer's appointment that are provided to the superintendent shall be handled in a manner that is consistent with the confidentiality provisions set forth in Subsection K of Section 59A-11-13 NMSA 1978.

(8) An insurer may terminate its relationship with an insurance producer for any of the reasons set forth in Subsection C of Section 59A-11-13 NMSA 1978. The provisions of Paragraphs (2) and (3) of Subsection C of 13.4.2.19 NMAC shall not apply for such terminations.

(9) When an insurer ceases operation in this state, all producers and other principals that have been appointed by the insurer shall cease to be authorized to transact business in this state on behalf of the insurer as of the date of such cessation and shall immediately cease all activity on behalf of the insurer.

[13.4.2.29 NMAC – Rp, 13.4.2.29 NMAC, 04/01/2025]

13.4.2.30 SUPERINTENDENT'S LICENSING RECORDS:

A. The superintendent shall keep a record of:

(1) each licensee's name, address, date of license, kind of business transacted and qualifications;

(2) the name of the principal or insurer represented; and

(3) all cancellations, suspensions or revocations of a license and notifications submitted by an insurer to the superintendent that pertain to a licensee.

B. Except for confidential information and other matters withheld by the superintendent pursuant to Sections 59A-2-12, 59A-4-11 or 59A-11-13 NMSA 1978, these records shall be made available for public inspection upon request.

[13.4.2.30 NMAC – Rp, 13.4.2.30 NMAC, 04/01/2025]

HISTORY OF 13.4.2 NMAC:

Pre-NMAC History: The material in this rule was originally filed with the State Records Center as:

ID 67-1, Sections 5-3-1 through

5-3-13 and 5-4-1 through 5-4-16, New Mexico Official Administrative Rules and Regulations Code, filed 12/1/1967.

History of Repealed Material:
13.4.2 NMAC - Resident Agents And Solicitors filed 7/1/1997, was Repealed effective 4/2/2018.

Other History of 13.4.2 NMAC:
13.4.2 NMAC - Resident Agents And Solicitors filed 7/1/1997, was Repealed and Replaced by 13.4.2 NMAC - Resident Producers And Other Resident Licenses effective 4/2/2018.
13.4.2 NMAC - Resident Producers And Other Resident Licenses, filed 4/2/2018 was repealed and replaced by 13.4.2 NMAC - Resident Producers And Other Resident Licenses, effective 04/01/2025.

SUPERINTENDENT OF INSURANCE, OFFICE OF

TITLE 13 INSURANCE
CHAPTER 4 LICENSING OF INSURANCE PROFESSIONALS
PART 3 NONRESIDENT PRODUCERS

13.4.3.1 ISSUING AGENCY: Office of Superintendent of Insurance (OSI).
[13.4.3.1 NMAC – Rp, 13.4.3.1 NMAC, 04/01/2025]

13.4.3.2 SCOPE: This rule applies to all persons seeking licensure as a nonresident insurance producer.
[13.4.3.2 NMAC – Rp, 13.4.3.2 NMAC, 04/01/2025]

13.4.3.3 STATUTORY AUTHORITY: Section 59A-2-9 NMSA 1978.
[13.4.3.3 NMAC – Rp, 13.4.3.3 NMAC, 04/01/2025]

13.4.3.4 DURATION: Permanent.
[13.4.3.4 NMAC – Rp, 13.4.3.4 NMAC, 04/01/2025]

13.4.3.5 EFFECTIVE DATE: April 1, 2025, unless a later date is cited at the end of a section.
[13.4.3.5 NMAC – Rp, 13.4.3.5 NMAC, 04/01/2025]

13.4.3.6 OBJECTIVE: The purpose of this rule is to implement Chapter 59A Articles 11, 12, 12A, 12B and 13 NMSA 1978, by establishing requirements for obtaining a license as a nonresident agent or nonresident broker.
[13.4.3.6 NMAC – Rp, 13.4.3.6 NMAC, 04/01/2025]

13.4.3.7 DEFINITIONS: For the purpose of this rule the following definitions apply:

A. "nonresident producer" is a person that resides in another state.
[13.4.3.7 NMAC – Rp, 13.4.3.7 NMAC, 04/01/2025]

13.4.3.8 LICENSING REQUIREMENTS: The superintendent may issue a license as a nonresident broker, or as a nonresident agent for life and health insurance only, to a person who maintains a bona fide continuous residence and a chief place of business within the continental limits of the United States, but not within the state of New Mexico, and who is licensed to engage in the business of insurance outside of New Mexico, under the following conditions:

A. Applicants shall pay in advance to the superintendent the fees prescribed in Section 59A-6-1 NMSA 1978.

B. Notwithstanding the conditions required under this rule, a nonresident broker shall be subject to retaliatory or reciprocal requirements, or both, with respect to any taxes, fines, penalties, licenses or fees in addition to or in excess of that imposed by the laws of this state upon nonresident brokers in New Mexico doing business in another state, or whenever any conditions precedent to the right to do business in another state are imposed by its laws beyond those imposed upon nonresident brokers by the laws of New Mexico, the same taxes, fines, penalties, licenses or fees and conditions precedent shall be imposed upon every similar nonresident broker in another state doing or applying to do business in New Mexico so long as the governing laws remain in force; and upon the failure of a nonresident broker to comply, the superintendent shall revoke the license in New Mexico, or shall refuse to grant a license or certificate in the first instance.

C. Pursuant to 18 U.S.C. Section 1033, no person who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a nonresident agent or a nonresident broker, unless the person has the written consent of the superintendent.
[13.4.3.8 NMAC – Rp, 13.4.3.8 NMAC, 04/01/2025]

13.4.3.9 TYPES OF INSURANCE LICENSES:

A. License required.

(1) No individual or business entity shall sell, solicit or negotiate insurance in this state unless licensed by the superintendent as an insurance producer for that line of insurance. Any person who is compensated for soliciting or accepting applications for health maintenance organization membership from the public shall be licensed as a health insurance producer in accordance with the provisions of Section 59A-46-17 NMSA 1978.

(2) A business entity that is licensed as an insurance producer shall employ licensed individual insurance producers to transact the types of insurance for which the business entity is licensed. Such an individual insurance producer shall hold a license of the same type as that of the business entity employer.

(3) Persons who engage in other transactions that are subject to the Insurance Code shall be licensed according to requirements set forth under relevant sections.

B. Producer license types based on lines of authority. An insurance producer may be qualified for one or more of the following lines of authority:

(1) casualty insurance, including coverage against legal liability, including for death, injury, disability or damage to real or personal property;

(2) property insurance, including coverage for direct or consequential loss or damage to property of every kind;

(3) accident and health or sickness insurance, including coverage for sickness, bodily injury or accidental death and may include benefits for disability income;

(4) life insurance, including coverage on human lives, benefits of endowment and annuities, and other benefits in the event of death or dismemberment by accident and may include benefits for disability income;

(5) variable life and variable annuity insurance, including contracts deemed to constitute securities that require that the producer also possess a license as a security salesman under other applicable state laws; and

(6) personal lines, including property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

C. Producer licenses for limited lines. An insurance producer may also be licensed for any of the following limited lines:

(1) credit insurance, as sold by individual producers who are employed full time by a vendor of merchandise or other property or by a financial institution that executes consumer loans which require credit life insurance, credit disability insurance, credit property insurance or credit involuntary unemployment insurance as set forth in Section 59A-25-1 et seq. NMSA 1978;

(2) travel insurance, as sold by producers who are qualified to solicit or sell travel insurance as set forth in Section 59A-12-18.1 et seq. NMSA 1978 and 13.4.2.14 NMAC;

(3) portable electronics insurance, as sold by vendors and their employees and representatives in accordance with the provisions of the Portable Electronics Insurance Act found at Section 59A-60-1 et seq. NMSA 1978 and as set forth in 13.4.2.21 NMAC;

(4) rental car insurance, as sold in connection with and incidental to the rental of vehicles by a rental car company and in accordance with the provisions of the Rental Car Insurance Limited Producer License Act found in Section 59A-32A-1 et seq. NMSA 1978 and as set forth in 13.4.2.15 NMAC;

(5) title insurance, as sold by title insurance business entities and the title insurance producers employed by them in accordance with the provisions of the New Mexico Title Insurance Law found in Section 59A-30-1 et seq. NMSA 1978 and as set forth in 13.4.2.13 NMAC; or

(6) motor club services, as sold by a registered representative and provided by a motor club holding a certificate of authority in this state in accordance with the provisions of the Motor Club Law found in Section 59A-50-1 et seq. NMSA 1978 and as set forth in 13.4.2.16 NMAC.

D. Other licenses required. Persons engaging in any of the following types of transaction under the insurance code shall also be licensed:

(1) persons acting as pharmacy benefits managers in accordance with provisions of the Pharmacy Benefits Manager Regulation Act found at Section 59A-61-1 et seq. NMSA 1978 and as set forth in 13.4.2.17 NMAC;

(2) persons offering membership in a prepaid dental plan in accordance with the provisions of the Prepaid Dental Plan Law found in Section 59A-48-1 et seq. NMSA 1978 and as set forth in 13.4.2.18 NMAC;

(3) persons engaged in the sale of prearranged funeral plans in accordance with the provisions of the Prearranged Funeral Plan Regulatory Law found in Section 59A-49-1 et seq. NMSA 1978 and as set forth in 13.4.2.19 NMAC;

(4) persons offering benefits to members through a fraternal benefit society as set forth in Section 59A-44-1 et seq. NMSA 1978 and 13.4.2.20 NMAC;

(5) persons acting as reinsurance intermediaries in accordance with the provisions of the Reinsurance Intermediary Law found at Section 59A-12D-1 et seq. NMSA 1978 and as set forth in 13.4.2.22 NMAC;

(6) persons selling services as insurance consultants in accordance with the provisions of Section 59A-11A-1 et seq. NMSA 1978 and as set forth in 13.4.2.23 NMAC;

(7) third-party administrators performing or providing any service, function, duty or activity in respect to any insurance plan, self-insurance or alternative to insurance in an administrative or management capacity in this state with respect to risks located or partially located in this state or on behalf of persons in this state in accordance with the provisions of Section 59A-12A-1 et seq. NMSA 1978 and as set forth in 13.4.5 NMAC;

(8) persons acting as independent, public and staff adjusters in accordance with the provisions of Section 59A-13-1 et seq. NMSA 1978 and as set forth in 13.4.8 NMAC; and

(9) persons acting as surplus lines brokers in accordance with the provisions of Section 59A-14-1 et seq. NMSA 1978 and as set forth in 13.4.4 NMAC.

[13.4.3.9 NMAC – Rp, 13.4.3.9 NMAC, 04/01/2025]

13.4.3.10 LICENSING REQUIREMENTS FOR INDIVIDUALS: The superintendent will issue, renew and continue nonresident licenses for individual

insurance producers to transact the kinds of insurance as set forth in 13.4.2.8 NMAC.

A. General requirements.

(1) An applicant shall be at least 18 years of age;

(2) an applicant shall file an application electronically or as otherwise specified by the superintendent;

(3) an applicant shall pay the fees required by Section 59A-6-1 NMSA 1978 as well as providing any additional bond, liability coverage or letter of credit that may be required by the license applied for;

(4) an applicant shall not have committed an act that is a ground for license denial, suspension or revocation under the Insurance Code; and

B. Application form.

(1) The application form may require the following information about the applicant:

(a) proof of the applicant's identity;

(b) name, date of birth, social security number and residence and business address;

(c) personal history;

(d) business experience, including experience, special training or education in the kind of business to be transacted under the license applied for;

(e) previous licensing information, including:

(i) whether the applicant was ever previously licensed to transact insurance in this state or elsewhere;

(ii) whether any license was ever refused, suspended or revoked;

(iii) whether any insurer claims that the applicant is indebted to it, and if so, the details of the claim; and

(iv) whether the applicant has ever had an insurance agency contract or appointment canceled and, if so, the facts of the cancellation;

(f) type of license applied for and kinds of insurance or transactions to be covered thereby;

(g) if the applicant will be adjusting workers' compensation claims, then an in-state physical address for the business entity;

(h) the NAIC number and name of the company holding a New Mexico certificate of authority that is sponsoring the applicant, if applicable;

(i) additional information relating to a particular type of license; and

(j) such other pertinent information and matters as the superintendent may reasonably require.

(2) The superintendent may require any application to be in the applicant's handwriting and under the applicant's oath.

C. Approval. Before approving a license application and issuing a license the superintendent shall confirm that:

(1) all of the applicant's answers to the questions on the application are complete, truthful and satisfactory, including acknowledgment and explanation of any prior criminal charges;

(2) the applicant has provided at least five years of employment history without gaps in the employment record;

(3) the applicant has provided a physical address where the home state license is maintained, and this address must match the most current information reported by NAIC; a post office box does not satisfy this requirement;

(4) pursuant to 18 U.S.C. Section 1033, no individual who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a nonresident producer, unless the person has the written consent of the home state and has provided acceptable verification to the superintendent by a method prescribed by OSI;

(5) the applicant has satisfied both the general and specific requirements and has provided any additional information necessary for the type of license requested or as required by the superintendent based the initial application answers;

(6) the applicant shall not use or intend to use the license solely to write insurance on the applicant's own life for the purpose of evading in spirit or intent the anti-rebate or anti-discrimination laws relating to insurance;

D. Prohibitions. Pursuant to Section 59A-12-11 NMSA 1978, the superintendent shall not license as an insurance producer or permit any such license to continue if the superintendent finds that an applicant for license intends to offer, give or sell stock or other ownership or participating interest in the agency or brokerage as inducement to or in connection with purchase of insurance or that the licensee has previously done so.

E. Contents of license. The contents of the license shall be consistent with the requirements set forth in Section 59A-11-9 NMSA 1978.

F. Special licensing requirements.

(1) Variable life and variable annuity or fraternal variable life and variable annuity license applications shall be deferred and reviewed manually by the superintendent. The applicant's FINRA and CRD numbers shall be supplied, and continued FINRA registration is required throughout the life of the license.

(2) Applicants shall apply for or actively hold a producer license for the life line of authority within the requested license class as follows:

(a) A variable life or a variable annuity producer license requires a life producer license.

(b) A variable life or a variable annuity consultant license requires a life insurance consultant license.

(c) A fraternal variable life or a variable annuity producer licenses requires a fraternal life producer license.

(d) A temporary variable life or a variable annuity producer license requires a temporary producer license.

(e) A viatical variable life or a variable annuity broker license requires a viatical life broker license.

(3) Surplus lines broker applicants shall actively hold both current property and casualty producer licenses or home state license equivalent prior to applying for a surplus lines broker license.

[13.4.3.10 NMAC – Rp, 13.4.3.10 NMAC, 04/01/2025]

13.4.3.11 LICENSING REQUIREMENTS FOR BUSINESS ENTITIES:

A. General requirements. A business entity acting as an insurance producer is required to obtain an insurance producer license pursuant to Sections 59A-11-3 NMSA 1978 and 59A-12-15 NMSA 1978.

(1) When licensing of a business entity is required, the application shall be filed by the business entity.

(2) The application shall be submitted electronically using the uniform business entity application or as otherwise specified by the superintendent.

(3) The business entity shall specify the business type as one of the following legal business types:

(a) partnership;

(b) limited liability company (LLC);

(c) limited liability partnership (LLP); or

(d) corporation.

A sole proprietorship may not apply for a business insurance producer license.

(4) The application shall be accompanied by payment of fees, as follows:

(a) all fees required pursuant to Section 59A-6-1 NMSA 1978;

(b) any bond or letter of credit required for the license applied for; and

(c) an additional license application filing fee for each individual in excess of one who is to exercise the license powers of the business entity, if not a general partner therein.

(5) The application shall be signed on behalf of the applicant by an authorized partner or corporate officer, under oath if required by the superintendent.

(6) If the business is a firm, then each individual who is not a bona fide general partner and who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

(7) If the business is a corporation, then each individual, whether or not an officer, director, stockholder or in other relationship to the corporation, who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

(8) If the business is a partnership, then each individual who is not a general partner and who is to exercise license powers shall file an application for a producer license for the same kind or kinds of business as that applied for by the business entity.

B. Application form. The application form may require information about the business entity as follows:

(1) the name, state of residence, proof of identity, business record, reputation and experience of each partner, officer, member of the board of directors and controlling stockholder of the business entity, and any additional information required of an individual applicant for a producer license as the superintendent deems necessary;

(2) evidence satisfactory to the superintendent that transaction of the business proposed to be transacted under the requested license is within the powers of the business entity as set forth in the entity's articles of incorporation, charter, bylaws, partnership, operating agreement or other governing documents;

(3) at least one individual is specified as the designated responsible licensed producer (DRLP) who is actively licensed in this state as either a resident or nonresident producer for each of the lines of authority applied for by the business entity;

(a) The DRLP(s) designated by the business entity shall cumulatively be licensed for all lines of authority of the business entity; except that

(b) business entities of the following types seeking a producer license are not required to designate a DRLP: portable electronics, rental car insurance producers and third party administrators; and

(4) such further information concerning the applicant, appointment of partners, corporate officers, directors and stockholders as may be requested by the superintendent.

C. Approval. The superintendent shall review the application and confirm that:

(1) all answers to the questions on the application are complete, truthful and satisfactory;

(2) the applicant holds active resident license in another state with the same or similar license for which the application is being submitted;

(3) the business entity has paid the fees set forth in Section 59A-6-1 NMSA 1978, as well as providing any additional bond, liability coverage or letter of credit that may be required by the type or types of license applied for;

(4) the business entity application lists at least one individual as an owner, officer, partner or director;

(5) the business entity has designated a licensed insurance producer responsible for the business entity's compliance with the insurance laws of this state for every line of authority listed in the application;

(6) the application sets forth the names of all the members, officers and directors of the business entity and the names of each individual who is to exercise the powers conferred by the license upon the business entity;

(7) the business entity license application uses the entity's legal name, unless an assumed name has been previously approved in writing by the superintendent; and

(8) at least one licensed insurance producer who is to exercise license powers is affiliated by submission of an application, and the application for affiliation was submitted with payment as required in Section 59A-6-1 NMSA 1978.

D. Prohibitions, Contents of license, Special licensing requirements. The provisions of Subsections D, E and F of 13.4.2.9 NMAC apply also to business entities seeking a producer license.

[13.4.3.11 NMAC – Rp, 13.4.3.11 NMAC, 04/01/2025]

HISTORY OF 13.4.3 NMAC:

Pre-NMAC History: The material in this rule was originally filed with the State Records Center as:

ID 67-1, Sections 5-3-1 through 5-3-13 and 5-4-1 through 5-4-16, New Mexico Official Administrative Rules and Regulations Code, filed 12/1/67.

History of Repealed Material: [RESERVED]

Other history of 13.4.3 NMAC:

13.4.3 NMAC - Nonresident Agents and Brokers, filed 11/30/2001 was repealed and replaced by 13.4.3 NMAC – Nonresident Producers, effective 04/01/2025.

SUPERINTENDENT OF INSURANCE, OFFICE OF

TITLE 13 INSURANCE
CHAPTER 4 LICENSING OF INSURANCE PROFESSIONALS
PART 4 SURPLUS LINES BROKERS

13.4.4.1 ISSUING AGENCY: Office of Superintendent of Insurance (OSI).

[13.4.4.1 NMAC – Rp, 13.4.4.1 NMAC, 04/01/2025]

13.4.4.2 SCOPE: This rule applies to all persons seeking licensure as a surplus lines broker.

[13.4.4.2 NMAC – Rp, 13.4.4.2 NMAC, 04/01/2025]

13.4.4.3 STATUTORY AUTHORITY: Title 59A, Chapter 14 and Section 59A-2-9 NMSA 1978.

[13.4.4.3 NMAC – Rp, 13.4.4.3 NMAC, 04/01/2025]

13.4.4.4 DURATION: Permanent.

[13.4.4.4 NMAC – Rp, 13.4.4.4 NMAC, 04/01/2025]

13.4.4.5 EFFECTIVE DATE: April 1, 2025, unless a later date is cited at the end of a section.

[13.4.4.5 NMAC – Rp, 13.4.4.5 NMAC, 04/01/2025]

13.4.4.6 OBJECTIVE: The purpose of this rule is to implement Chapter 59A Article 14 NMSA 1978 by establishing requirements for obtaining a license as a surplus lines broker.

[13.4.4.6 NMAC – Rp, 13.4.4.6 NMAC, 04/01/2025]

13.4.4.7 DEFINITIONS: For the purpose of this rule, **"surplus lines broker"** has the meaning given in Section 59A-14-2 NMSA 1978.

[13.4.4.7 NMAC – Rp, 13.4.4.7 NMAC, 04/01/2025]

13.4.4.8 LICENSING REQUIREMENTS:

A. An applicant requesting a license as a surplus lines broker shall file, as part of the application, a bond as required by this rule. The application for a surplus lines broker will be considered for issuance by the superintendent upon the payment in advance to the superintendent of the fees prescribed in Section 59A-6-1 NMSA 1978.

B. On or before the first day of March of each year, OSI will mail a billing statement for renewal of the surplus lines broker license to each surplus lines broker licensed in New Mexico.

C. On or before the first day of April of each year, the surplus lines broker shall return the billing statement together with the license renewal fee specified in Section 59A-6-1 NMSA 1978.

D. Pursuant to 18 U.S.C. Section 1033, no person who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a surplus lines broker, unless the person has the written consent of the superintendent.

[13.4.4.8 NMAC – Rp, 13.4.4.8 NMAC, 04/01/2025]

13.4.4.9 REQUIRED EXPERIENCE, TRAINING AND EDUCATION: To meet the requirements of Section 59A-14-7 NMSA 1978, an applicant for a surplus lines broker license shall file, as part of the application, documentation showing a combination of the following factors totaling at least five years:

A. Experience as a licensed agent in the kind of insurance for which the surplus lines broker license is sought;

B. Continuing education units of a type and quantity sufficient to satisfy the requirements for renewal of an agent's license; and

C. Any other special experience, education or training that the applicant offers to demonstrate that the applicant is reasonably competent to conduct surplus lines business in New Mexico.

[13.4.4.9 NMAC – Rp, 13.4.4.9 NMAC, 04/01/2025]

HISTORY OF 13.4.4 NMAC:
Pre-NMAC History: The material in this rule was originally filed with the State Records Center as ID 67-1, Sections 5-4-1, 5-4-4, and 5-4-14 through 5-4-16, New Mexico Official Administrative Rules and Regulations Code, filed 12/1/1967.

History of Repealed Material: [RESERVED]

Other history of 13.4.4 NMAC:
13.4.4 NMAC - Surplus Lines Brokers, filed 11/30/2001 was repealed and replaced by 13.4.4 NMAC - Surplus Lines Brokers, effective 04/01/2025.

SUPERINTENDENT OF INSURANCE, OFFICE OF

TITLE 13 INSURANCE
CHAPTER 4 LICENSING OF INSURANCE PROFESSIONALS
PART 7 CONTINUING EDUCATION REQUIREMENTS

13.4.7.1 ISSUING AGENCY: Office of Superintendent of Insurance (OSI)
[13.4.7.1 NMAC - Rp, 13.4.7.1 NMAC, 04/01/2025]

13.4.7.2 SCOPE:

A. This rule applies to all licensed adjusters, insurance producers, limited surety agents, bail bond solicitors, property bondsmen, and nonresident insurance producers unless exempted by Subsection B of this section.

B. The continuing education requirements of this rule shall not apply to:

(1) holders of limited licenses issued pursuant to Section 59A-12-18 NMSA 1978;

(2) licensees who have been continuously licensed by the superintendent for 25 years or more, without a lapse of more than 90 days;

(3) persons who maintain a license solely for the purpose of receiving renewal fee residuals and who do not otherwise transact the business of insurance;

(4) agents of fraternal benefit societies licensed pursuant to Section 59A-44-33 NMSA 1978; or

(5) nonresident insurance licensees who are licensed in another state or country that requires completion of continuing education courses.
[13.4.7.2 NMAC - Rp, 13.4.7.2 NMAC, 04/01/2025]

13.4.7.3 STATUTORY AUTHORITY: Sections 59A-2-9, 59A-6-1, 59A-11-10, 59A-11-23, 59A-12-16, 59A-12-26, 59A-13-12, 59A-44-33, 59A-51-4.1 NMSA 1978.
[13.4.7.3 NMAC - Rp, 13.4.7.3 NMAC, 04/01/2025]

13.4.7.4 DURATION: Permanent.
[13.4.7.4 NMAC - Rp, 13.4.7.4 NMAC, 04/01//2025]

13.4.7.5 EFFECTIVE DATE: April 1, 2025, unless a later date is cited at the end of a section.
[13.4.7.5 NMAC - Rp, 13.4.7.5 NMAC,04/01/2025]

13.4.7.6 OBJECTIVE: The purpose of this rule is to set forth continuing education requirements for persons who are licensed by the superintendent to transact business in this state and for continuing education providers.
[13.4.7.6 NMAC - Rp, 13.4.7.6 NMAC, 04/01/2025]

13.4.7.7 DEFINITIONS: As used in this rule:

A. "adjuster" means a resident or non-resident public adjuster, staff adjuster or independent adjuster as defined in Section 59A-13-2 NMSA 1978;

B. "approved course" means a course of instruction approved by the coordinator as satisfying the continuing education requirements of this rule or that has been previously approved by another state with which New Mexico has reciprocal privileges and that has been submitted by the provider and approved by the coordinator;

C. "bail bondsman" has the same definition as in Subsection A of Section 59A-51-2 NMSA 1978;

D. "biennially" means every two years or during the 24 months next preceding expiration of the current license;

E. "business day" means Monday through Friday, excluding holidays observed by the state.

F. "classroom course" means a course of instruction approved by the coordinator as satisfying the continuing education requirements of this rule or that has been previously approved by another state with which New Mexico has reciprocal privileges and that has been submitted by the provider and approved by the coordinator.

G. "classroom equivalent course" means a type of classroom study that is instructor-led, delivered using the internet to remote attendees, with a specific start time and end time, in which students enroll before gaining access to the instructor, information, and course activities. Student attendance is monitored and validated based on personally identifiable information (e.g., username, password, email) and student participation in interactive exercises is required.

H. "compliance period" means the time period between the issue date or last renewal date of the license to the expiration date of the license for purposes of satisfying the continuation requirements;

I. "continuing education coordinator" or **"coordinator"** means an independent entity approved by the superintendent that receives and reviews continuing education compliance courses, instructors, providers, applications, and renewal applications. The official title of the coordinator for use in formal documents shall be "the

New Mexico Insurance Continuing Education Coordinator";

J. "credit hour" means 50 minutes of actual instruction or self-study time in an approved course;

K. "ethics course" means a course that deals with usage and customs among members of the insurance profession, involving moral and professional conduct and fiduciary obligations and duties toward one another, toward clients, toward insureds, and toward insurers and of responsible insurance agency management;

L. "insurance producer" means a person required to be licensed under the laws of the state of New Mexico to sell, solicit or negotiate insurance;

M. "licensee" means an adjuster, insurance producer, limited surety agent, bail bond solicitor, property bondsman or nonresident insurance producer within the scope of this rule;

N. "limited surety agent" has the same definition as in Subsection C of Section 59A-51-2 NMSA 1978;

O. "non-contact" means self-study;

P. "nonresident licensee" means a person licensed in this state pursuant to Section 59A-11-23 NMSA 1978;

Q. "property bondsman" has the same definition as in Subsection D of Section 59A-51-2 NMSA 1978;

R. "provider" means a person who is authorized by the superintendent to provide approved continuing education courses for licensees and report licensee attendance for credit toward continuing education requirements;

S. "qualified instructor" means, for purposes of this rule, a person who has demonstrated competency in the subject matter of an approved course through one of the following means:

(1) a college degree from an accredited institution of higher learning with a major in insurance; or

(2) a professional designation of CLU or CPCU or similar designation from an industry association; or

(3) three or more years of practical experience in the subject matter being taught or monitored; and

(4) a qualified instructor shall not have been subject to any order of revocation, suspension, or other formal disciplinary action in any state;

T. "roster" is an official list of licensees who have successfully completed an offering of an approved course;

U. "self-study" means course activities or information delivered outside of real time (recorded or otherwise similarly accessible) and available at any time, such as but not limited to correspondence, online training, video, audio, compact disk (CD) or digital versatile disk (DVD). Student attendance is verified based on identity (e.g., username, password, email, signature) and successful completion of knowledge assessments or an examination;

V. "seminar" means a type of classroom study that is instructor-led, delivered in person or using the internet to remote attendees, with a specific start time and end time, in which students enroll before gaining access to the instructor, information, and course activities. Student attendance is monitored and validated based on personally identifiable information (e.g., username, password, email) and student participation in interactive exercises is required;

W. "solicitor" has the same definition as in Subsection E of Section 59A-51-2 NMSA 1978;

X. "staff" means any OSI employee or a contractor approved by the superintendent of insurance; and

Y. "superintendent" means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

[13.4.7.7 NMAC - Rp, 13.4.7.7 NMAC, 04/01/2025]

13.4.7.8 INSURANCE CONTINUING EDUCATION COORDINATOR:

A. The superintendent will appoint an insurance continuing education coordinator to approve individual courses of instruction for continuing education credit, notify the superintendent of approved courses as they are approved, make recommendations regarding continuing education courses and perform other tasks as assigned by the superintendent.

B. The continuing education coordinator shall not approve any continuing education course that does not provide a method by which a provider can confirm that a licensee has completed the course.

C. Coordinator requirements for continuing education review:

(1) Course application: the coordinator shall review each course application to determine whether the course meets the established requirements and to determine the number of credit hours for each education topic that a licensee may earn by completing the course;

(2) the coordinator shall employe or contract with, and shall train and supervise, individuals who have the requisite knowledge, skills, and abilities to competently review, evaluate, and render sound decisions on, and otherwise process applications for course approval;

(3) the coordinator shall possess and develop sufficient knowledge in each education topic prescribed by the OSI;

(4) education topics include ethics, flood insurance, long-term care partnership, and general (other insurance education meeting continuing education standards);

(5) the coordinator shall develop, implement, and ensure adherence to, policies and procedures for evaluating applications for curse approval. The coordinator may include as part of the policies and procedures a method for conducting an expedited review of an application. A coordinator that is a contractor to OSI and that intends to charge a different price to process a course application expeditiously shall include that price on the price sheet in response to an OSI solicitation;

(6) the coordinator shall review courses delivered through classroom instruction, instruction by audio media, instruction by video media, instruction from printed materials, computer-based instruction, webinars, and courses to be delivered via other course-delivery methods;

(7) the coordinator shall facilitate multi-state approval of a course, including accepting and reviewing applications submitted on systems and forms developed by the coordinator or on systems and forms developed by the NAIC, affiliates of the NAIC and business partners of the NAIC;

(8) the coordinator shall be required to ensure that the content of course instruction meets continuing education standards, to ensure that the instruction is presenting correct and current material, and to assign the correct number of credit hours to each education topic; and

(9) the coordinator shall render appropriate decisions concerning each course application within a thirty-day time period or shall notify the OSI in writing (email is acceptable) that the course review was not completed within the thirty-day period, explaining why the timeframe was not met.

D. If a course application is approved, the coordinator shall:

(1) Notify the approved provider that the course was approved including the approved course number and course title assigned to the course, the number of credit hours assigned to each education topic and the total credit hours assigned to the course; and

(2) provide the approved provider an efficient means to issue a certificate of compliance to each licensee who completes the course, including instruction to the approved provider on how to properly complete a certificate of compliance.

E. If a course application is incomplete, the coordinator shall send a notice of deficiency to the approved provider and shall require the approved provider to respond to all deficiencies within 30 calendar days. The coordinator's 30-day time frame shall be suspended from the date the coordinator sends the notice of deficiency to the date the coordinator receives a response from the approved provider.

F. Before disapproving a complete course application that does not meet the continuing education standards, the coordinator shall give the approved provider an opportunity to eliminate the problem or barrier preventing the course from being approved as an approved course.

G. If a course application is disapproved, the coordinator shall provide the reason for the denial to the approved provider, and shall inform the approved provider about their appeal rights.

H. The coordinator shall develop, maintain and administer policies and procedures for handling appeals of course application denials, and the coordinator shall testify to, and support, in any appeal proceeding, decisions made by the coordinator.

I. If the OSI establishes another education topic that the coordinator shall consider when evaluating course applications, the coordinator shall, at no charge, facilitate and consider an approved provider's request to reallocate the credit hours awarded to an approved course to newly established types or categories of education.

J. The coordinator shall develop, maintain and administer policies and procedures for the retention of, disposition of, and public accessibility to, course applications, application decisions and associated correspondence. All documents shall be retained by the coordinator for ten years after the date of receipt.

[13.4.7.8 NMAC - Rp, 13.4.7.8 NMAC, 04/01/2025]

13.4.7.9 REQUIREMENTS FOR LICENSEES:

A. Hours required biennially.

(1) All licensees shall complete a minimum of three hours of credits in ethics during each compliance period. Ethics credit hours may be included toward the total credit hour requirement for each license type.

(2) Title insurance licensees shall complete ten credit hours of approved courses covering title insurance. At least three credit hours shall specifically cover the proper handling of escrow funds. These three hours can also be used to satisfy the requirement for three credit hours in ethics.

(3) Limited surety agents, property bondsmen, solicitors and bail bond solicitors shall complete 14 hours of approved courses covering the Bail Bondsmen Licensing Law, Sections 59A-51-1 et seq. NMSA 1978 and related regulations during each two-year compliance period.

(4) All other licensees shall complete 24 credit hours of approved courses covering some or all of the kinds of insurance for which they are licensed during each compliance period. Licensees who transact insurance under multiple lines of authority are only required to satisfy a single 24 hour continuing education requirement for each compliance period.

(5) Adjusters who are licensed prior to July 1, 2017 shall satisfy continuing education credits prior to renewal of licenses beginning with the first biennial

renewal cycle occurring after April 30, 2018.

(6) Non-resident licensees are not required to complete New Mexico's continuing education requirements if the home state requires continuing education and the licensee has complied with the continuing education requirements of the home state, pursuant to the provisions of Section 59A-11-23 NMSA 1978.

B. No carryover. No licensee may carry over credit hours earned in a compliance period to the next compliance period.

C. No duplicate credit. No additional credit will be granted to a licensee for completion of the same approved course more than once in any compliance period.

D. Course completion date. Course credits are applied to licensing requirements based on the date that the course is taken, rather than on the date that the course credit is reported by the provider.

E. Course approval. Licensees shall receive course credit only for courses that have been approved by the coordinator prior to enrollment in the course.

F. Extensions. Licensees who meet the criteria of illness, medical disability, military deployment or circumstances beyond the control of the licensee may apply for an extension of time to complete their continuing education requirement or a waiver, in whole or in part, of the continuing education requirement.

(1) The superintendent shall establish the duration of the extension when it is granted.

(2) If the circumstances supporting the extension continue beyond the granted extension period, the licensee may reapply for an extension.

(3) The licensee shall request the extension prior to the end of the compliance period for which it applies, using the form available on the OSI website.

(4) Licensees called to active military service in a combat theater, may apply for an exemption from or an extension of time for meeting the continuing education requirements or extending their license renewal. The licensee shall request the extension or waiver prior to the end of the compliance period, using the form available on the OSI website.

G. Reinstating a discontinued license. A licensee whose license is discontinued shall complete all required continuing education credits before submitting an application for reinstatement.
[13.4.7.9 NMAC - Rp, 13.4.7.9 NMAC, 04/01/2025]

13.4.7.10 COURSE CONTENT:

A. Course length. Individual courses shall be a minimum of one credit hour in length.

B. Ethics. A single continuing education course may include both ethics and other insurance topics meeting the requirements of Subsection C of this section.

C. Insurance subjects.

(1) General instruction time shall be designed to refresh the licensee's understanding of basic insurance principles and coverages, applicable laws and regulations, and recent and prospective changes to them.

(2) Required hours for specialized training requirements shall be completed prior to transacting the type of insurance and may also be counted toward the 24-credit-hour general producer licensee requirement.

(a) Producers desiring to transact business relating to stop loss insurance shall complete at least eight credit hours relating specifically to stop loss insurance.

(b) Adjusters and producers desiring to transact business relating to flood insurance shall complete at least four credit hours relating specifically to flood insurance within one year of the effective date of this rule.

(c) Producers shall not transact business relating to long term care until they have completed at least eight hours of continuing education relating specifically to long term care, and shall complete at least four hours of continuing education relating specifically to long term care during each compliance period thereafter. The course shall include topics relating to long term care partnership for producers who wish to transact long term care partnership business. Producers who transact long term care insurance as of the effective date of this rule shall have one year following the effective date of this rule to complete the eight-hour initial course requirement.

(3) Required training shall not focus specifically on training that is insurer- or company-product specific and may not include sales or marketing information.

D. Approved learning formats.

(1) A course may utilize classroom instruction, lectures, seminars, panel discussions, question-and-answer periods, correspondence courses, online web-based courses and recorded presentations, as long as the provider can ensure that a licensee has completed the course.

(2) A minimum of three hours of continuing education course hours for each compliance period shall be earned through participation in a formal classroom or in another learning format that permits the student to interact with a live instructor. Licensees are responsible for tracking this requirement and are subject to audit by the superintendent.

E. Self-study course requirements. A self-study course shall include:

(1) clearly defined objectives and course completion criteria;

(2) material that is current, relevant, accurate, and that includes valid reference materials, graphics, and interactivity;

(3) specific instructions to register, navigate, and complete the course work;

(4) at least enough questions to fashion a minimum of two versions with at least fifty percent of the questions being new or different in each subsequent version; and

(5) process for:

(a) authenticating student identity such as passwords and security prompts;

(b) measuring the student's success in completing a course that includes the material, exam, and any proctor requirements; and

(c) requesting and receiving the continuing education course completion certificate and reporting student results; and

(6) instructors or subject matter experts shall be available to answer student questions during provider business hours. A technical support or provider representative should be available during business hours, and responses to student questions should be provided withing twenty-four hours of initial contact.

F. Control of access to self-study course material and examinations. A student shall enroll for the course before having any access to course material. The course provider shall prevent all students from:

(1) having any access to the course examination before the student has reviewed all course materials;

(2) downloading any course examination; and

(3) printing or viewing the examination prior to reviewing all course materials.

G. Self-study course review questions. The course provider shall provide review questions at the end of each unit and chapter and shall prevent access to the final examination until each set of review questions is answered at a seventy percent success rate. The course provider shall provide final examination questions that do not duplicate unit or chapter review questions.

H. Self-study final examination criteria. The course provider shall provide a minimum of ten questions for each one-credit hour course and five additional questions for each subsequent credit hour. The student shall achieve a score of seventy percent or greater to pass the examination.

[13.4.7.10 NMAC - Rp, 13.4.7.10 NMAC, 04/01/2025]

13.4.7.11 PROVIDER AND COURSE REQUIREMENTS:

A. Provider qualifications. Prior to submitting proposed courses to the coordinator for approval, the provider shall submit the following information and be approved as a provider:

(1) the name and contact information for the provider's primary contact person;

(2) the provider's physical and mailing address;

(3) the provider's website address;

(4) a link that will be provided for licensees to review course dates, location, and content;

(5) procedures that will be used to process online enrollment in courses, including payment via credit card; and

(6) experience and qualifications of the course instructors.

B. Course content. To obtain approval of a course, a provider shall ensure that:

(1) the curriculum offered relates to insurance subjects, or subjects which relate to the individual licensee's transaction of insurance business;

(2) the course has significant intellectual or practical content and that its primary objective is to increase the participant's professional competence as a licensee; and

(3) pursuant to Subsection B of Section 59A-12-26 NMSA 1978, instruction shall be designed to refresh the licensee's understanding of:

(a) basic principles and coverages involved,

(b) applicable insurance laws and regulations,

(c) proper conduct of the licensee's business,

(d) duties and responsibilities of the licensee, and

(e) to address recent and prospective changes.

C. Course approval.

(1) The provider's course application to the coordinator shall include, at a minimum, the following information:

(a) a statement identifying the knowledge, skills, or abilities the licensee is expected to obtain through completion of the course;

(b) a detailed course content outline showing the approximate times for major topics;

(c) a detailed description of the course materials, including a course content word count, that demonstrates that the course supports the number of credit hours requested;

(d) the method of evaluation by which the provider measures how effectively the course meets its objectives and provides for student input;

(e) the total number of course hours requested for approval, including the method the applicant is using to determine the number of course hours and the number of hours included in the total number of course hours requested for approval that are ethics topics;

(f) the course application fee as specified in Section 59A-6-1 NMSA 1978; and

(g) for applicants determining self-study course hours by using the average of approved times in other states, a list of

all course approved times and the states in which the course is approved;

(2) Prior approval. A provider shall submit each course for review and receive approval of the course prior to making that course available for enrollment by licensees. If the coordinator determines that the course content is incomplete or inadequate, the provider will be notified and required to supplement or modify the course before receiving approval.

(3) Renewals. The original course application fee covers the period until the initial expiration of the course. Courses shall be resubmitted for renewal, along with the renewal fee specified in Section 59A-6-1 NMSA 1978. Courses will not automatically be re-approved by the coordinator.

(4) Electronic course submission. Beginning July 1, 2017 any provider wishing to have a course approved by the coordinator, shall submit each course for approval electronically. Instructions for electronic submission of courses may be found on the OSI website. Providers should allow up to 60 days for the coordinator to approve a new course.

(5) Course expiration. All continuing education courses already approved by the coordinator at the time of the adoption of the final version of this regulation by the superintendent, will expire on April 1, 2025. All courses approved by the coordinator thereafter will expire two years after the date the course is approved.

(6) Voluntary cancellation. Providers shall notify the superintendent when a course is discontinued or no longer active and when there is a change to the provider's information of record.

(7) Non-voluntary course cancellation. Approved courses shall be cancelled and the content updated, as necessary, to reflect changes in the law or regulations. Failure of the provider to update courses in a timely manner may result in cancelation of the course by the superintendent.

D. Statement of approved courses. Providers of approved courses shall include the following written statement in the course materials for each approved course: "This course has been approved by the New Mexico Insurance Continuing Education Coordinator as New Mexico Insurance Continuing Education Course Number (insert number) for (insert number) hours of credit."

E. Instructors. A provider of an approved course shall ensure that instructors for all courses are qualified by practical or academic experience to teach the subject to be covered. No instructor shall present a course without prior approval by the OSI coordinator. An instructor shall submit a request for approval through an online application prescribed by the superintendent. With the submission of each instructor application, the provider must include a list of courses the applicant will be instructing. This list may be updated by the provider contact using the method prescribed by the OSI.

F. Enrollment. Providers shall make available a current list of scheduled courses including course content, applicable credits, course dates, instructor information and course location as appropriate. Providers shall collect course fees at the time of registration.

G. Minimum classroom requirements.

(1) Courses shall comply with the approved learning formats listed in Subsection D of 13.4.7.10 NMAC.

(2) A disinterested third party attendant, an instructor, or a disinterested third party using visual observation technology shall visually monitor attendance either inside or at all exits of the course presentation area at all times during the course presentation.

(3) An instructor shall be involved in each classroom presentation of the course, but in circumstances involving remote presentations, all students and the instructor do not need to be in the same location. Students may attend remotely via the internet or other real-time format. While presenting recorded or text materials, the instructor making the live course presentation does not have to be the same instructor included on the recorded presentation or who prepared the text materials.

(4) Question and answer discussion periods shall be provided by either an instructor making a live presentation of the course to licensees in the same room, or via real-time live audio or audio-visual connection which shall allow for student inquiries and responses with the presenting instructor, or by an instructor who is present for the entire remote, recorded, or computer-based course presentation with the students in the same room.

(5) The course pace shall be set by the instructor and does not allow for independent completion of the course by students.

(6) Providers may not include time spent by students on the final examination and pre-tests in determining course credit hours.

H. Course completion. A provider shall ensure that each licensee completes the course by either:

(1) monitoring the course to witness attendance and participation; or

(2) requiring submission of a test or other written work evidencing understanding of the course material.

I. Reciprocal courses. In order for a licensee to receive credit for a reciprocal course, the reciprocal course shall be approved in the provider's home state and have been submitted by the provider in its entirety to the coordinator for prior approval. The coordinator may choose to deny approval of any course hours that are related to the home state's laws or regulations or may deny any material, based on the NAIC's guidance.

J. Submission of roster. Within 10 business days after the completion of the course of instruction by a licensee, the provider shall electronically submit an attendance roster to the superintendent. The provider shall also provide documentation of course completion to each producer that successfully completed the course with 10 business days of completion.

K. Records. A provider shall maintain records of attendance and course completion for a minimum of three years and make such records available to the superintendent or the coordinator at any time upon request.

L. Audits. The OSI staff or the coordinator may conduct audits of any course or provider without prior notice to the provider. OSI staff or a designee may attend courses without identifying themselves as employees or representatives of OSI. If continuing education records are audited or reviewed and the validity or completeness of the records are questioned, the provider shall have 30 days from the date of notice to correct discrepancies or submit new documentation.

[13.4.7.11 NMAC - Rp, 13.4.7.11 NMAC, 04/01/2025]

13.4.7.12 REPORTING REQUIREMENTS:

A. Reporting by providers. Continuing education providers are required to report completion of continuing education courses to the superintendent. However, it is the responsibility of the individual resident licensee to ensure that the superintendent's records reflect the completion of the required number of continuing education courses on or before the continuing education due date. The licensee shall correct any discrepancies in the record through the continuing education provider.

B. Transition and reporting after July 1, 2017:

(1) All continuing education courses shall be completed and reported prior to renewal of the license. Licensees who fail to complete the required continuing education courses will not be permitted to renew the license, which will result in immediate termination of the license, pursuant to Section 59A-11-10 NMSA 1978.

(2) For individual licensees who were issued or who renewed a one-year agent, broker, or solicitor license prior to July 1, 2017, the license shall be renewed for a biennial insurance producer or bail bondsmen's license by April 30, 2018. Prior to that renewal, the individual licensee shall have completed 15 hours of continuing education courses, including at least one hour in ethics, as was required at the time the license was issued or renewed.

(3) For all biennial licenses issued after July 1, 2017, the licensee shall renew on the last day of the second birth month following issue of the license, such that the initial compliance period shall be no less than 13 months and no more than 24 months in length. Prior to renewal, licensees shall complete the required number of continuing education courses, as set forth in Subsection A of 13.4.7.9 NMAC. The compliance period for completion of continuing education courses is the period between issue of the license and renewal on or before the last day of the licensees second birth month following issue.

(4) Thereafter, insurance producer licenses shall be renewed biennially on or before the last day of the licensee's birth month. Required continuing education courses shall be completed and reported during the compliance period, which is the twenty-four-month period immediately preceding renewal of the license. In order to allow time for the provider to report course attendance prior to expiration of the license, students should plan accordingly in order to avoid payment of penalties.

C. Fees. A licensee shall submit all continuing education fees prescribed by Subsection E of Section 59A-12-26 NMSA 1978 to the provider. The provider will then submit the hourly course fee electronically to the superintendent on behalf of the licensee. Registration fees are nonrefundable for licensees who fail to attend or fail to successfully complete a course. Instructions for electronic submittal of fees may be found on each provider's website and on the OSI website.

D. Records.

(1) The licensee is responsible for confirming that all continuing education credits have been correctly recorded by the provider. The licensee may print a copy of the entire educational transcript for reference purposes. Instructions for reviewing and printing the transcript may be found on the OSI website.

(2) It is recommended that all licensees maintain copies of certificates of completion of approved courses and verified statements for a period of three years.

(3) Individual continuing education credit information can be reviewed by the licensee, by the public or by the superintendent. Instructions for viewing continuing education information may be found on the OSI website.

(4) The superintendent shall be notified electronically of any noncompliance with the continuing education requirements by licensees.

[13.4.7.12 NMAC - Rp, 13.4.7.12 NMAC, 04/01/2025]

13.4.7.13 AUDITING PROCEDURES:

A. All continuing education records submitted or maintained pursuant to this rule are subject to audit by the superintendent.

B. If the superintendent finds a licensee or provider has failed to timely report continuing education credits through the online system, the superintendent may impose a penalty.

C. A provider who fails to submit the roster to the superintendent within 10 business days may be subject to removal from the list of approved continuing education providers in the state. Instructions for submitting the roster shall be provided to approved course providers.

[13.4.7.13 NMAC - Rp, 13.4.7.14 NMAC, 04/01/2025]

HISTORY OF 13.4.7 NMAC:

Pre-NMAC history. The material in this rule was previously filed with the State Records Center as:

SCC 85-2, In Re to Article II: Rules Regarding Continuing Education Requirements, on April 17, 1985;

SCC-85-11, Insurance Department Regulation 12 - Insurance Agents,

Brokers and Solicitors, on October 10, 1985;
SCC-91-3-IN, Continuing Education Requirements of Insurance Agents, Brokers, and Solicitors, on January 31, 1992.

NMAC history.
Recompiled as 13 NMAC 4.7, Continuing Education Requirements, effective 7/1/1997.
13.4.7 NMAC, Continuing Education Requirements, effective 5/1/2002.
13.4.7 NMAC, Continuing Education Requirements, effective 5/1/2002 was Repealed and Replaced by 13.4.7 NMAC, effective 2/27/2018.

History of repealed material.
13 NMAC 4.7, Continuing Education Requirements, Repealed 5/1/2002
13.4.7 NMAC Continuing Education Requirements, filed 5/1/2002 – Repealed effective 2/27/2018.

Other history of 13.4.7 NMAC:
13.4.7 NMAC – Continuing Education Requirements, filed 2/27/2018 was repealed and replaced by 13.4.7 NMAC - Continuing Education Requirements, effective 04/01/2025.

SUPERINTENDENT OF INSURANCE, OFFICE OF

This is an amendment to 13.4.8 NMAC, Sections 1, 2, 3, and 7 through 13 and 15 through 17, effective 4/1/2025.

13.4.8.1 ISSUING AGENCY: Office of Superintendent of Insurance (OSI) [~~Producer Licensing Bureau (PLB)~~].
[13.4.8.1 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.2 SCOPE: This rule applies to resident and non-resident persons seeking licensure to provide adjusting services in this state, as defined in Article 13 of Chapter 59A NMSA 1978.
[13.4.8.2 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.3 STATUTORY AUTHORITY: [~~Sections 59A-2-8, and 59A-13-1 et seq.~~] Title 59A, Chapter 13 and Section 59A-2-9 NMSA 1978.
[13.4.8.3 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.7 DEFINITIONS: As used in this rule:

A. "Adjuster" has the meaning provided in Paragraph (1) of Subsection A of Section 59A-13-2 NMSA 1978.

B. "Advertisement" is as set forth in [~~Subsection~~] Section 19 of this rule.

C. "Business entity" has the meaning provided in Paragraph (3) of Subsection A of Section 59A-13-2 NMSA 1978.

D. "Catastrophic disaster" means an event that results in large numbers of deaths and injuries; causes extensive damage or destruction of facilities that provide and sustain human needs; produces an overwhelming demand on state and local response resources and mechanisms; causes a severe long-term effect on general economic activity; or severely affects state, local and private sector capabilities to begin and sustain response activities. For purposes of this rule, a catastrophic disaster shall be declared by the president of the United States, the governor of the state, or the superintendent of insurance.

[~~**E. "Designated home state"** is used when the adjuster's home state does not license adjusters and means a state in which an adjuster does not maintain his, her, or its principal place of residence or business, but in which the adjuster is licensed in good standing and has designated as the home state for purposes of compliance with licensing regulations.~~]

E. "Designated home state" means a home state as defined in Paragraph (4) of Subsection A of Section 59A-13-2 NMSA 1978, in which the adjuster is licensed and in good standing, and that is designated by the adjuster for purposes of compliance with licensing regulations when the adjuster's home state:

(1) does not license independent adjusters and does not restrict a staff adjuster from obtaining that license in New Mexico; or

(2) does not license staff adjusters, does not require staff adjusters to be licensed, and does not restrict staff or independent adjusters from obtaining that license in New Mexico.

F. "Equivalent" means comparable qualifications, examination or licensing criteria, or scope of duties.

[~~**F**~~] **G. "Home state"** [~~means the District of Columbia or any state or territory of the United States which is the principal place of residence or principal place of business for an insurance adjuster and in which the adjuster is licensed to provide services as a resident adjuster~~] has the same meaning as defined in Paragraph (4) of Subsection A of Section 59A-13-2 NMSA 1978.

[~~**G**~~] **H. "Independent adjuster"** [~~means an adjuster who is not a staff adjuster or a public adjuster and includes a representative or an employee of an independent adjuster. An independent adjuster is a professional who conducts investigations, verifications, negotiations, and settling of claims for or on behalf of an insurance company, a self-insured firm, or a government agency, without being under the employment of the company, firm, or agency in question.~~] has the same meaning as defined in Paragraph (5) of Subsection A of Section 59A-13-2 NMSA 1978.

[~~**H**~~] **I. "Insurance"** has the meaning set forth in Section 59A-1-5 NMSA 1978.

[~~**I**~~] **J. "Negotiate"** means the act of conferring directly with or offering advice directly to a person whose real or personal property is covered under a policy of insurance regarding a claim or claims for loss or damage with the objective of arriving at a settlement.

[~~**J**~~] **K. "Nonresident adjuster"** means an adjuster who has a current resident license in the

adjuster's home state or designated home state, and who has applied for and received a nonresident adjuster's license in this state. A nonresident adjuster may be licensed only for the same type or types of adjuster's license for which the adjuster is licensed in the home state or designated home state.

[~~K~~] L. **"Public adjuster"** [~~means an adjuster who, for direct or indirect compensation or any other thing of value on behalf of the insured:~~

~~(1) acts or aids, investigates, negotiates, settles, adjusts, advises or otherwise assists an insured with a claim or claims for loss or damage under any policy of insurance covering the insured person's real or personal property, or on behalf of any other public insurance adjuster who is acting on behalf of an insured;~~

~~(2) advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as an public adjuster of first-party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or~~

~~(3) directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy, for the insured.~~] has the same meaning as defined in in Paragraph (6) of Subsection A of Section 59A-13-2 NMSA 1978.

[~~L~~] M. **"Resident of the state"** means an individual who maintains a principal home in New Mexico and holds no active resident insurance license in another state.

[~~M~~] N. **"Resident adjuster"** [~~means an adjuster who resides principally in New Mexico and who conducts business primarily in New Mexico or who has designated New Mexico as the home state for purposes of licensing~~] has the same meaning as defined in Section 59A-13-2 NMSA 1978;

[~~N~~] O. **"Staff adjuster"** [~~a person who is a salaried employee of an insurer or an affiliate of the insurer, and who is engaged in adjusting insured losses solely for that company or other companies under common control or ownership~~] has the same meaning as defined in Section 59A-13-2 NMSA 1978.

[~~O~~] P. **"Superintendent"** means the superintendent of insurance, the office of superintendent of insurance or employees of the office of superintendent of insurance acting within the scope of the superintendent's official duties and with the superintendent's authorization.

Q. **"Terminate"** means becomes inactive.

[13.4.8.7 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.8 LICENSE REQUIRED:

A. No individual or business entity shall act as or make any representation as being an adjuster unless licensed as such by the superintendent, nor shall such person accept a commission, service fee or other valuable consideration for investigating or settling claims in New Mexico if that person is required to be licensed and is not so licensed.

B. No person, regardless of location, shall act as, or make any representation as being, an adjuster with respect to workers' compensation claims of claimants resident or located in New Mexico unless licensed as such by the superintendent. Pursuant to Section 59A-13-11 NMSA 1978, each workers' compensation insurer shall have at least one claims representative within New Mexico, licensed as an adjuster, to pay workers' compensation claims of claimants resident or located in New Mexico. Such claims shall be paid promptly through such representatives from accounts in financial institutions located within New Mexico.

C. A business entity may not be licensed as an adjuster unless at least one officer, active partner, or other managing individual of the business entity, and each individual performing acts of an insurance adjuster on behalf of the business entity in this state, are individually licensed by the superintendent separately from the business entity with the same adjuster license as the business. The business entity shall designate a licensed adjuster responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

D. Each license shall contain:

(1) the name of the insurance adjuster;

(2) the date of issuance and the date of expiration of the license; and

(3) if applicable, the name of the firm with which the insurance adjuster is employed at the time the license is issued.

E. An individual may be licensed as both an independent and staff adjuster, but must apply separately for each.

F. Each licensee who is a resident of this state or a business entity organized under the laws of this state shall:

(1) maintain a place of business in this state which shall be easily accessible to the public and is the place where the adjuster principally conducts transactions under the license;

(2) maintain in the place of business the required records; and

(3) notify the superintendent of any change in the address of the licensee's place of business within 20 days or be subject to a penalty of fifty dollars ($50).

G. No later than 30 days after moving within a state or from one state to another state, a nonresident adjuster's licensed in this state shall file with the superintendent:

(1) the licensee's new address, and

(2) proof of authorization to act as an insurance adjuster in any new state of residence if that state requires licensure of insurance adjusters.

[13.4.8.8 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.9 LICENSING REQUIREMENTS FOR INDIVIDUAL ADJUSTERS: The superintendent will issue, renew and continue adjuster's licenses for individual adjusters as follows:

A. Electronic submission. The individual applicant shall submit the application electronically or as otherwise directed by the superintendent.

B. Individual requirements. The superintendent shall issue an individual adjuster's license only to an individual who is otherwise in compliance with Chapter 59A, Articles 11 and 13 NMSA 1978 and who has furnished evidence satisfactory to the superintendent that the applicant for license:

(1) is not less than 18 years of age;

(2) is a bona fide resident of this state, or of a state or country that permits residents of this state to act as adjusters therein, except that under circumstances of necessity the superintendent may waive the requirement of reciprocity;

(3) is trustworthy, reliable and can demonstrate a good business reputation, and intent to engage in a bona fide manner in the business of adjusting insurance claims;

(4) has passed the examination required for licensing;

(5) shall not have committed an act that is a ground for license denial, suspension or revocation under the Insurance Code;

(6) has paid the license fee, as set forth in Section 59A-6-1 NMSA 1978; and

(7) <u>if applying for a public adjuster license</u>, has filed the bond as required 13.4.8.11 NMAC, or otherwise demonstrated financial responsibility, as approved by the superintendent.

C. Exceptions for staff adjuster. Paragraphs (2) and (7) of Subsection B of this section shall not apply as to staff adjusters.

D. Exceptions for prior license holders. Individuals holding licenses as adjusters as of July 1, 2017, shall be deemed to meet the qualifications for the license except as provided in Chapter 59A, Articles 11 and 13 NMSA 1978. The examination requirement is waived provided that the individual's license is not allowed to terminate through lapse, or otherwise.

E. Additional requirement for public adjusters. An applicant for a license to act as a public adjuster must, as part of the application, endorse an authorization for disclosure to the superintendent of all financial records of any funds the public insurance adjuster holds as a fiduciary using the form available on the OSI website. The authorization shall continue in force and effect while the public adjuster continues to be licensed in this state.

F. Application form.

(1) The application form may require the following information about the applicant:

(a) proof of the applicant's identity;

(b) name, date of birth, social security number, residence and business addresses, and email address;

(c) personal history;

(d) business experience, including experience, special training or education pertaining to insurance adjusters;

(e) previous licensing information, including:

(i) whether the applicant was ever previously licensed to transact insurance or adjusting in this state or elsewhere;

(ii) whether any license was ever refused, suspended or revoked;

(iii) whether any insurer or member of the public claims that the applicant is indebted to it, and if so, the details of the claim; and

(iv) whether the applicant has ever had a contract or appointment with an insurer canceled and, if so, the facts of the cancellation;

(f) type or types of adjuster's license applied for;

(g) if the applicant will be adjusting workers' compensation claims, then an in-state physical address for the business entity;

(h) the NAIC number and name of the company holding a New Mexico certificate of authority that is sponsoring the applicant, if applicable;

(i) such other pertinent information and matters as the superintendent may reasonably require.

(2) The superintendent may require any application to be in the applicant's handwriting and under the applicant's oath.

G. Approval. Before approving an application and issuing a license, the superintendent shall confirm that:

(1) all of the applicant's answers to the questions on the application are complete, truthful and satisfactory, including acknowledgment and explanation of any prior criminal charges;

(2) if the applicant is applying for a resident license, the applicant does not currently hold an active New Mexico resident or nonresident license or an active resident license in another state;

(3) if the applicant is applying for a resident license, the applicant has provided an in-state residential or business address (a post office box does not satisfy this requirement), unless the applicant has designated New Mexico as the home state for licensing purposes only;

(4) if the applicant is applying for a nonresident license, the applicant currently holds an active resident license in another state or designated home state that requires an examination. A nonresident who has an active staff adjuster license shall qualify for an independent adjuster license upon proper application. A nonresident who has an active independent adjuster license shall qualify for a staff adjuster license upon proper application;

(5) if applying for a resident license, the applicant has passed the required examination, or if applying for a nonresident license, the applicant has passed the required examination in the applicant's home state or designated home state;

(6) the applicant has provided at least five years of employment history without gaps in the employment record;

(7) the applicant's fingerprints have been submitted for purposes of a state and federal background check, and

(a) pursuant to 18 U.S.C. Section 1033, no individual who has been convicted of a felony involving dishonesty or a breach of trust may be licensed as a resident adjuster, unless the person has the written consent of the superintendent;

(b) pursuant to the Criminal Offender Employment Act found at Section 28-2-1 et seq. NMSA 1978, any prior criminal record shall be considered in connection with application for any license; and

(c) if the results of the background check have not been received or indicate a need for further investigation, the application will not be approved pending further review;

(8) the applicant has satisfied both the general and specific requirements and has provided any additional information necessary for the adjuster's license requested or as required by the superintendent based the initial application answers;

(9) the applicant has submitted the application fee as set forth in Section 59A-6-1 NMSA 1978; and

(10) if the applicant for a resident license is a citizen of a foreign county, then the application shall include proof that the applicant is eligible to reside and work in the United States.

H. Requirements for nonresident applicants and licensees.

(1) A nonresident adjuster's licensee must designate the superintendent for service of process in accordance with the application requirement for nonresident licensees.

(2) Upon submission of the required application and payment of the license fee set forth in Section 59A-6-1 NMSA 1978, the superintendent may issue a nonresident license to an applicant for an adjuster's license who is not a permanent resident of this state, if the applicant is currently licensed as a resident adjuster in the applicant's home state or designated home state and the applicant satisfies all of the following:

(a) currently holds a valid adjuster's license, of the same type as the license applied for, in another state that requires a qualifying examination of sufficient scope as required by the superintendent;

(b) meets the requirements set forth in Subsection B of this section;

(c) is self-employed as an adjuster or associated with or employed by a business entity or other adjuster in the adjuster's home state or designated home state; and

(d) discloses whether the applicant has ever had any license or eligibility to hold any license declined, denied, suspended, or revoked, whether the applicant has ever been placed on probation and whether an administrative fine or penalty has been levied against the applicant and, if so, the reason for the action.

(3) Each individual who holds a nonresident license shall comply with all requirements of this rule and with other rules and laws of this state applicable to adjusters, including the requirements on record maintenance for each license type and for financial responsibility as set forth in 13.4.8.11 NMAC.

[~~**(4)** As a condition of doing business in this state, a nonresident adjuster shall submit an affidavit certifying that the licensee is familiar with and understands the laws set forth in Article 13 of 59A NMSA 1978, these rules, and the terms and conditions of the types of insurance contracts that provide coverage on real and personal property. The affidavit shall be provided initially and upon renewal, using the form available on the OSI website. Compliance with this filing requirement is necessary for the issuance, continuation, reinstatement, or renewal of a nonresident adjuster's license.~~]

[13.4.8.9 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.10 LICENSING REQUIREMENTS FOR BUSINESS ENTITIES:

A. Individual licenses required. A business entity that is licensed as a public or independent adjuster, or as both, shall employ licensed individual adjusters to adjust the types of claims for which the business entity is licensed. Such individuals shall hold an adjuster's license of the same type or types as that of the business entity employer.

B. General adjuster licensing requirements for business entities. Any resident or nonresident business entity that desires a license as a public or independent adjuster [~~, or as both,~~] shall file a completed application or applications with the superintendent, pursuant to Sections 59A-11-3 and 59A-12-15 NMSA 1978.

(1) The business entity shall be:

(a) organized under the laws of this state

or any other state or territory of the United States;

(b) admitted to conduct business in this state by the secretary of state, if required; and

(c) authorized by its articles of incorporation or its partnership agreement to act as a public or independent adjuster; and

(2) The business entity's application or applications shall:

(a) be filed by the business entity;

(b) be submitted electronically or as otherwise specified by the superintendent;

(c) specify the business type as one of the following legal business types:

(i) partnership;

(ii) limited liability company (LLC);

(iii) limited liability partnership (LLP); or

(iv) corporation; but not as a

(v) sole proprietorship;

(d) be accompanied by payment of fees, as follows:

(i) all fees required pursuant to Section 59A-6-1 NMSA 1978;

(ii) a bond or evidence of financial responsibility as set forth in 13.4.8.11 NMAC; and

(iii) an additional license application filing fee for each individual in excess of one who is to exercise the license powers of the business entity, if not a general partner therein;

(e) designate an individual licensed adjuster who is responsible for the business entity's compliance with the insurance laws, rules and regulations of this state; and

(f) be signed on behalf of the applicant by an authorized partner or corporate officer, under oath if required by the superintendent.

(3) If the business is a firm, then each individual who is not a bona fide general partner and who is to exercise license powers, shall file an application for the same type of adjuster's license as that applied for by the business entity.

(4) If the business is a corporation, then each individual, whether or not an officer, director, stockholder or in other relationship to the corporation, who is to exercise license powers shall file an application for the type of adjuster's license as that applied for by the business entity.

(5) If the business is a partnership, then each individual who is not a general partner and who is to exercise license powers, shall file an application for the same type of adjuster's license applied for by the business entity.

(6) The business entity shall list by name each licensed individual who is to operate under the business entity license.

C. Application form. The application form may require information about the business entity as follows:

(1) the name, state of residence, proof of identity, business record, reputation and experience of each partner, officer, member of the board of directors and controlling stockholder of the business entity, and any additional information required of an individual applicant for an adjuster's license as the superintendent deems necessary;

(2) evidence satisfactory to the superintendent that transaction of the business proposed to be transacted under the requested license is within the powers of the business entity as set forth in the entity's articles of incorporation, charter, bylaws, partnership, operating agreement or other governing documents;

(3) at least one individual is specified as the designated responsible adjuster who is actively licensed in this state as either a resident or nonresident adjuster for each type of adjuster's license applied for by the business entity. The designated responsible licensed adjusters designated by the business entity shall cumulatively be licensed for all types of adjuster's license of the business entity; and

(4) such further information concerning the applicant, appointment of partners, corporate officers, directors and stockholders as may be requested by the superintendent.

D. Approval. The superintendent shall review the application and confirm that:

(1) the applicant meets all of the requirements set forth in Subsections B and C of this section;

(2) all answers to the questions on the application are complete, truthful and satisfactory;

(3) the applicant does not already hold an active resident or nonresident license in New Mexico or, if applying for a resident license, an active resident license in another state;

(4) the business entity has paid the fees set forth in Section 59A-6-1 NMSA 1978;

(5) the business entity application lists at least one individual as an owner, officer, partner or director;

(6) the business entity has designated a licensed adjuster responsible for the business entity's compliance with the laws of this state;

(7) the application sets forth the names of all the members, officers and directors of the business entity and the names of each individual who is to exercise the powers conferred by the license upon the business entity;

(8) the business entity license application uses the entity's legal name, unless an assumed name has been previously approved in writing by the superintendent; and

(9) at least one licensed adjuster who is to

exercise license powers is affiliated by submission of an application, and the application for affiliation was submitted with payment as required in Section 59A-6-1 NMSA 1978.

E. Special licensing requirements. The following apply to business entities seeking an adjuster's license:

(1) The business entity intends to be actively engaged in the business of public or independent adjusting.

(2) No officer, director, member, manager, partner, or any other person who has the right or ability to control the license holder has:

(a) had a license suspended or revoked or been the subject of any other disciplinary action by a financial or insurance regulator of this state, another state, or the United States; or

(b) committed an act for which a license may be denied under the Insurance Code without prior authorization from the superintendent.

(3) Nothing contained in this section shall be construed to permit any unlicensed employee or representative of any business entity to perform any act of a public or independent adjuster without obtaining that type of adjuster's license.

(4) Each corporation or partnership shall notify the superintendent not later than the 30th day after the date of:

(a) a felony conviction of a licensed adjuster of the entity or any individual affiliated with the business entity; and

(b) an event that would require notification under the Insurance Code.

(5) If a licensee does not maintain the qualifications necessary to obtain the license, the superintendent shall revoke or suspend the license or deny the renewal of the license.

(6) Each adjuster shall maintain all required records, including all records relating to customer complaints received from customers and the superintendent.

F. Portable electronics. A business entity applying for an independent adjuster's license for the purposes of portable electronics insurance shall comply with the filing requirements set forth in Subsection D of Section 59A-13-4 NMSA 1978.

[13.4.8.10 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.11 PROOF OF FINANCIAL RESPONSIBILITY:

A. Prior to issuance of a license as an independent or public adjuster to an individual and for the duration of the license, the applicant shall file with the superintendent a surety bond in favor of the superintendent in aggregate amount of not less than ten thousand dollars, conditioned to pay actual damages resulting to this state or any member of the public in this state from violation of law by the licensee while acting as an adjuster. The bond shall be one executed by an authorized surety insurer and offered by a producer licensed and appointed in this state.

B. A surety bond used to maintain and demonstrate proof of financial responsibility under this section shall:

(1) remain in effect for the duration of the license, or until the surety is released from liability by the superintendent, or until canceled by the surety;

(2) be in the form specified by the superintendent;

(3) be executed by the insurance adjuster as principal and a surety company authorized to do business in this state as surety;

(4) be payable to the superintendent for the use and benefit of an insured, conditioned that the insurance adjuster shall pay any final judgment recovered against it by an insured;

(5) provide that the surety will give no less than 30 days prior written notice of bond termination to the licensee and the superintendent;

(6) be separate from any other financial responsibility obligation; and

(7) not be used to demonstrate financial responsibility for any other license, certification, or person.

C. [~~The applicant or licensee may file with the superintendent a cash bond, a professional liability policy or similar policy or contract of professional liability coverage in like amount acceptable to the superintendent, in lieu of the surety bond.~~

~~**D.**~~] Each public [~~or independent insurance~~] adjuster [~~must~~] shall obtain separate proof of financial responsibility and may not rely on the bond of any other [~~insurance~~] adjuster to demonstrate proof of financial responsibility.

[~~**E**~~] **D.** The superintendent may ask for [~~the~~] evidence of financial responsibility at any time that the superintendent deems relevant.

[~~**F**~~] **E.** The authority to act as a public or independent adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

[13.4.8.11 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.12 EXAMINATION OF APPLICANTS:

A. Examinations required. An individual applying for a license as an adjuster shall, prior to issuance of a license, personally take and pass a written examination. The examination required by this section shall be of sufficient scope to reasonably test the applicant's:

(1) knowledge, experience or training relating to the assessment of:

(a) real and personal property values; and

(b) physical loss of or damage to real or personal property that may be the subject of insurance and claims under insurance;

(2) knowledge of the duties and responsibilities of an adjuster holding the type of adjuster's

license applied for as set forth by law and regulation in this state, including ethical and fair trade practices;

(3) knowledge of basic insurance theory, the essential elements of contracts, and claims, and ethics terms and effects of the types of insurance contracts that provide coverage on real and personal property;

(4) knowledge and experience adequate to enable an adjuster holding the type of adjuster's license applied for to engage in the business as an adjuster fairly and without injury to the public or any member of the public with whom the applicant may have business as an adjuster; and

(5) technical competence in the handling of the types of claims for which the applicant is being tested.

B. Examination exemptions.

(1) Examination is not required for an individual who was licensed in this state as an adjuster prior to July 1, 2017, unless the license is allowed to lapse or is terminated for any reason, as set forth in Subsection D of 13.4.8.9 NMAC.

(2) Examination is not required for applicants who have taken and passed [~~a similar~~] an equivalent examination and received the same type of adjuster's license in a state in which the reciprocal provisions of Section 59A-5-33 NMSA 1978 apply; and

(a) the license in the other state is current, or

(b) the application is received within 90 days after cancellation of the previous license [~~If the license has been canceled and~~] if verified records maintained by the NAIC indicate that the adjuster is or was licensed in good standing for the type of license applied for. [~~then the following is required:~~

~~**(i)** a certification from the reciprocal state that at the time of cancellation the applicant was in good standing in that state; or~~

~~**(ii)** records maintained by the NAIC indicate that the adjuster is or was licensed in good standing for the type of license applied for.~~]

(3) Reexamination is not required for renewal or continuance of resident or designated home state licenses, unless ordered by the superintendent.

(4) Reexamination is not required for resident applicants who have been licensed in this state within the year prior to the date of the new application and who seek to be relicensed for the same types of adjuster's license. This exemption does not apply if the previous license was suspended, revoked or terminated, if continuation of the license was refused by the superintendent or if the applicant did not previously take and pass an exam in this state.

(5) Examination is not required for a nonresident applicant who is licensed by designating a home state other than the state of residence, if the state of licensure requires the passing of a written examination in order to obtain the license and is a reciprocal state.

[~~**(6)** Examination is not required for an applicant currently licensed as an adjuster in another state who moves to this state and applies to become a resident insurance adjuster within 90 days of establishing legal residence. For such applicants, the examination requirement is waived as to licensure for the type of adjuster's license previously held in the prior state, unless otherwise determined by the superintendent.~~]

C. Examination fee. Each individual applying for an examination shall remit a nonrefundable fee as set forth in Section 59A-6-1 NMSA 1978.

D. Administration of exams. The superintendent may contract with an outside testing service for administering examinations and collecting the nonrefundable fee.

E. Failure to appear. An individual who fails to appear for an examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination. [13.4.8.12 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.13 CONTINUATION, NONRENEWAL, CANCELLATION, DENIAL, REVOCATION, SUSPENSION, TERMINATION AND REINSTATEMENT OF LICENSE:

A. Continuation and nonrenewal of adjuster's licenses. Unless the license is canceled, revoked, suspended or otherwise terminated, an adjuster's license is continuous, subject to payment by the due date of renewal fees as set forth in Section 59A-6-1 NMSA 1978, and for individual licensees, compliance with the continuing education requirements set forth in 13.4.7 NMAC.

(1) For resident licenses issued to individuals:

(a) Biennial renewal fees shall be paid on or before the last day of the second occurrence of the individual's birth month following issuance of the license.

(b) Continuing education requirements shall be satisfied during the 24 months immediately preceding the issuance and renewal date of the license. Additional information pertaining to continuing education requirements is set forth at 13.4.7 NMAC.

(c) An individual who is unable to comply with license renewal requirements due to military service, disability or other extenuating circumstance may request a waiver [~~using forms available on the OSI website or as otherwise~~] as directed by the superintendent. [~~An adjuster in such circumstances may also request a waiver of a fine or sanction imposed for failure to comply with renewal procedures.~~]

(d) If the superintendent has reason to

believe that the competence of any individual licensee is in question, the superintendent may require as a condition of continuation of the license that the individual licensee take and pass the written examination that is required for new applicants for the same license.

(e) If an adjuster's license has been expired for one year or more, the adjuster applicant must submit to reexamination. Reexamination must be completed within the 12 months preceding the application.

(2) For licenses issued to business entities:

(a) Business entity licenses shall renew and continue on a biennial basis on March 1 of the biennial year, subject to payment of fees as set forth in Section 59A-6-1 NMSA 1978.

(b) Business entity affiliations shall renew and continue on an annual basis on March 1 of every year, subject to payment of fees pursuant to Section 59A-6-1 NMSA 1978.

(3) For nonresident licenses issued to individuals:

(a) As a condition of the continuation of a nonresident adjuster's license, the licensee shall maintain a resident adjuster's license of the same type in the adjuster's home state or designated home state.

(b) The licensee shall pay the biennial renewal fees on or before the last day of the second occurrence of the individual's birth month following issuance of the license.

(c) If the licensee's home state requires continuing education substantially equivalent to that of this state as set forth in 13.4.7 NMAC for renewal of the adjuster's license and the licensee has satisfied the continuing education requirements of the home state, then the licensee may renew the nonresident adjuster's license in this state. [~~with evidence that the licensee is compliant with the continuing education requirement of the home state.~~

~~**(d)** If the home state does not require continuing education, the nonresident license cannot be renewed until the licensee:~~

~~**(i)** completes the hours required for renewal of the New Mexico resident license by completing courses offered by a continuing education provider that have been approved by the continuing education committee in this state, or~~

~~**(ii)** completes equivalent continuing education requirements for license renewal for a state that the licensee has designated as the home state; and~~

~~**(iii)** uploads the certificates of completion electronically or as otherwise directed by the superintendent.~~]

B. Reasons for suspension, revocation or refusal to continue license. The superintendent [~~may~~] will suspend, revoke, or refuse to issue or renew an adjuster's license [~~or~~] and may levy a fine or penalty [~~or any combination of the above actions~~] for any one or more of the following causes:

(1) providing incorrect, misleading, incomplete or materially untrue information in the license application;

(2) violating any insurance laws, regulations, subpoena or order of the superintendent or of another state's insurance commissioner, including engaging in any unfair trade practices or fraud;

(3) obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) improperly withholding, misappropriating, or converting any monies or properties received in the course of doing insurance business;

(5) intentionally misrepresenting the terms of an actual or proposed insurance contract or settlement offer;

(6) committing an illegal act that is a ground for license denial, suspension or revocation under the Insurance Code;

(7) using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility, in the conduct of insurance business in this state or elsewhere;

(8) having an insurance or adjuster's license probated, suspended, revoked or refused in any other state;

(9) forging another's name to any document related to an insurance transaction;

(10) cheating, including improperly using notes or any other reference material, to complete an examination for an adjuster's license;

(11) failing to comply with an administrative or court order imposing a child support obligation; [~~or~~]

(12) termination or cancelation of evidence of financial responsibility, as set forth in 13.4.8.11 NMAC; or

(13) a business entity's failure to renew affiliations timely.

C. Termination of licenses.

(1) [~~Adjuster's~~] Adjuster licenses are subject to termination for any of the reasons set forth in Subsection B of 13.4.2.27 NMAC.

(2) If a nonresident adjuster's license is terminated by the home state or designated home state for any reason, the nonresident adjuster's license shall terminate immediately, unless the termination is due to the adjuster being issued a resident adjuster's license in a new home state. If there is a change in the home state, then the notice of change must include both the previous and current addresses. If the new home state does not have reciprocity with this state, the nonresident adjuster's license shall terminate.

D. Effects of suspension. While a license is suspended, the licensee shall not engage in any transaction for which the license is required, other

than transfer of business that was transacted by the licensee while the license was active.

E. Application for license after suspension, denial of application, or revocation of license. Adjuster's licenses are subject to the provisions for reinstatement as set forth in Subsection C of 13.4.2.27 NMAC.

(1) An adjuster whose license is suspended by the superintendent may apply for a new license only after the expiration of the period of suspension.

(2) In the event that the action by the superintendent is to revoke or deny application for licensure or refuse renewal of an existing license, the superintendent shall notify the applicant or licensee in writing, advising of the reason for the refusal. The applicant or licensee may request a hearing to be held within 30 days.

(3) Paragraph (2) of this subsection does not apply to an applicant whose license application was denied for failure by the applicant to:

(a) pass the required written examination; or

(b) submit a properly completed license application.

F. Action against business entities. The license of a business entity may be probated, suspended, revoked, or refused if the superintendent finds, after a hearing, that its designated individual licensee's violation occurred while acting on behalf of or representing the business entity and that the violation was known or should have been known by one or more of the business entity's partners, officers or managers and that the violation was neither reported to the superintendent nor was corrective action taken.

G. Disciplinary proceeding for conduct committed before surrender or forfeiture of license. The superintendent shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by the Insurance Code against any person who is under investigation for or charged with a violation of this regulation even if the person's license has been surrendered or has expired by operation of law.

(1) The superintendent may institute a disciplinary proceeding against a former licensee for conduct that the licensee committed before the effective date of a voluntary surrender or automatic forfeiture of the license.

(2) In a proceeding under this section, the fact that the license holder has surrendered or forfeited the license does not affect the license holder's culpability for the conduct.

[13.4.8.13 NMAC – N, 7/1/2019; A, 04/01/2025]

13.4.8.15 STAFF ADJUSTERS:

A. Description of staff adjusters. A staff adjuster is an employee of an insurance company whose work is to investigate, evaluate, and eventually settle a claim. In certain situations, a staff adjuster may award the claim to the insured (by writing a check [~~in~~] on behalf of the company). Evidence of financial responsibility as described in 13.4.8.11 NMAC is not required of licensed staff adjusters.

B. Powers of staff adjusters. A staff adjuster shall have only such powers with respect to claims and losses as granted by the staff adjuster's employer or affiliates of the staff adjuster's employer.

C. Appointment required. A staff adjuster must be appointed by an insurance company in order to be licensed in this state.

(1) If the appointment of a licensed staff adjuster is terminated by an insurance company for any reason, notice shall be provided to the superintendent within [~~10~~] 30 calendar days from the date of termination.

(2) After a staff adjuster's appointment by the insurance company is terminated, the staff adjuster's license will terminate automatically if the superintendent is not notified that the staff adjuster has been appointed by another insurance company within 30 calendar days after submission of the initial notice that the appointment has been terminated.

D. Examination requirement.

(1) Although the initial examination requirement is waived for adjusters who were licensed prior to July 1, 2017, the examination waiver is lost if the adjuster's license is terminated for any reason after July 1, 2017, including loss of the staff adjuster's appointment. Once a license is terminated and the waiver is lost, the adjuster must pass the required examination before the license will be reinstated.

(2) The applicant must pass the required examination within one year prior to applying for the license. If a staff adjuster who has passed the required examination is without an appointment or is otherwise unlicensed for more than one year, reexamination will be required before the license can be reinstated.

[13.4.8.15 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.16 INDEPENDENT ADJUSTERS:

A. Description of independent adjusters.

(1) An independent adjuster is a professional who conducts investigations, verification, negotiations, and settling of claims for or on behalf of an insurance company, a self-insured firm, or a government agency, without being under the employment of the company, firm, or agency in question but has entered into a valid contract with the insurer or third-party firm.

(2) Independent adjusters either are hired through a third-party firm that specializes in handling claims or are self-employed entities. A licensed independent adjuster may be outsourced by an insurer to handle claims in this state.

(3) Independent adjusters are generally

utilized for one of the following reasons:

(a) to assist an insurer following a major catastrophe resulting in a manpower shortage to investigate and negotiate on its behalf;

(b) for statutory reasons or to comply with provisions of an insurance contract;

(c) to meet a need for special expertise; or

(d) to deal with claims in remote areas.

B. Powers and responsibilities of independent adjusters. An independent adjuster shall have the powers granted by its principal to investigate, report upon, adjust and settle claims on behalf of an insurer or self-insurer and have additional powers as to claims and losses only as may be conferred by the principal.

C. Standards of conduct of independent adjusters. In addition to the general standards of conduct that apply to all adjusters as set forth in 13.4.8.14 NMAC, an independent adjuster shall also self-identify as an independent adjuster and, if applicable, identify the adjuster's employer when dealing with any policyholder or claimant.

D. Records of independent adjusters.

(1) Each independent adjuster shall keep at the business address shown on his license a record of all transactions under the license. The records shall include:

(a) documents relating to all investigations or adjustments undertaken, and

(b) a statement of any fee, commission or other compensation received or to be received by the adjuster on account of such investigation or adjustment.

(2) The adjuster shall make such records available for examination by the superintendent at all reasonable times, and shall retain records as to a particular investigation or adjustment for not less than three years after completion of such investigation or adjustment.

(3) Failure of a licensed independent adjuster, as determined by the superintendent after notice and an opportunity for a hearing, to properly maintain records in accordance with this section and make them available to the superintendent on request constitutes grounds for the suspension of the license.

[13.4.8.16 NMAC - N, 7/1/2019; A, 04/01/2025]

13.4.8.17 POWERS AND RESPONSIBILITIES OF PUBLIC ADJUSTERS:

A. General authority. A licensed public adjuster may adjust claims on behalf of insured clients for property claims, both real and personal, including loss of income. Although business entities can be licensed as a both public and independent adjuster, an individual adjuster that is licensed as a public adjuster shall not be licensed additionally as either a staff or independent adjuster.

B. Standards of conduct. In addition to the general standards of conduct that apply to all adjusters as set forth in 13.4.8.14 NMAC, public adjusters shall also adhere to the following legal and ethical requirements:

(1) All contracts for the services of a public adjuster and required disclosures shall be executed in writing and shall comply with the specific requirements set forth in Section 59A-13-15 NMSA 1978. A sample contract and sample disclosure form, which may be used by a public adjuster, are available on the OSI website. Use of the sample contract and disclosure will be accepted by the superintendent as compliance with this requirement.

(2) A public adjuster shall serve with objectivity and complete loyalty in the interest of the public adjuster's client alone and shall render to the client such information, counsel and service as will best serve the client's insurance claim needs and interest.

(3) A public adjuster shall not solicit, or attempt to solicit, a client during the progress of a loss-producing occurrence, as defined in the client's insurance contract.

(4) Unless disclosed to the client in writing, a public adjuster shall not refer or direct the client to get needed repairs or services in connection with a loss from any person:

(a) with whom the public adjuster has a financial interest; or

(b) from whom the public adjuster may receive direct or indirect compensation for the referral.

(5) Unless disclosed to the client in writing, a public adjuster shall not accept any compensation or anything of value in connection with a client's specific loss in exchange for the referral of a client to any third-party individual or firm, attorney, appraiser, umpire, construction company, contractor, or salvage company. Such disclosure shall include the source and amount of any such compensation.

(6) A public adjuster shall not agree to any settlement without the client's knowledge and consent.

(7) An individual public adjuster, while so licensed by the superintendent, shall not be licensed as a staff adjuster or an independent adjuster.

(8) The contract between the public adjuster and the client shall not be construed to prevent a client from pursuing any civil remedy after the three-business day revocation or cancellation period.

(9) A public adjuster shall not engage in the unauthorized practice of law.

C. Misrepresentation.

(1) A public adjuster shall not misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as a staff adjuster employed by the insurer or acting as an independent adjuster.

(2) A public adjuster shall not make a misrepresentation, in violation of Insurance Code, to an insured or to an insurance company in the conduct of their actions as public adjusters.

D. Public adjuster fees.

(1) The public adjuster's contract shall disclose that the public adjuster is hired by and compensated by the insured to assist in preparation, presentation and settlement of the claim. The contract shall disclose that the public adjuster's fee or commission shall be paid by the insured from the proceeds of the settlement, and shall state whether the compensation is based on a percentage of the settlement.

(2) No public adjuster shall require, demand or accept any fee, retainer, compensation, deposit, or other thing of value prior to settlement of a claim and collection of money due to be paid by an insurance company. The public adjuster shall not collect the entire fee from the first check issued by an insurance company. Rather, the public adjuster's fees shall be paid as a percentage of each check issued by an insurance company.

(3) A public adjuster shall not pay a commission, service fee or other valuable consideration to a person for investigating or settling claims in this state if that person is required to be licensed pursuant to the Insurance Code and is not so licensed.

(4) A person shall not accept a commission, service fee or other valuable consideration for investigating or settling claims in this state if that person is required to be licensed pursuant to the Insurance Code and is not so licensed.

(5) In the event of a catastrophic disaster, there shall be limits on catastrophic fees that a public adjuster shall charge, agree to, or accept as compensation or reimbursement. Any payment, commission, fee, or other thing of value shall not exceed ten percent of any insurance settlement or proceeds.

E. Records of public adjusters. Records of public adjusters shall be maintained in compliance with Section 59A-13-17 NMSA 1978.

F. Fiduciary duties of public adjusters.

(1) Escrow or trust accounts. Public adjusters shall comply with the escrow and trust account requirements set forth in Section 59A-13-16 NMSA 1978.

(2) Handling of funds.

(a) All funds of others received by a public adjuster, including funds received as claim proceeds shall be received and held by the public adjuster in a fiduciary capacity. A public adjuster may not divert or appropriate fiduciary funds received or held. [~~An adjuster who diverts or appropriates such funds for personal use or takes or secrets such funds with intent to embezzle without the consent of the person entitled to the funds is subject to fines and penalties set forth in the Insurance Code and is guilty of larceny.~~]

(b) Subject to the terms of any agreement between an adjuster and the adjuster's principal or obligee, each adjuster who does not make immediate remittance of funds to the insured or other person entitled to them shall elect and follow one of the following methods:

(i) forward insurance funds received (less applicable compensation, if any) to the insured or person entitled thereto within 15 days after receipt; or

(ii) establish and maintain one or more fiduciary bank accounts separate from accounts holding personal, firm or corporate funds, and promptly deposit and retain therein all funds of others pending transmittal to the insured or person thereto entitled.

(c) The following exceptions to the prohibition against commingling of funds shall apply:

(i) Funds belonging to more than one principal may be deposited and held in the same account so long as the amount held for each principal is readily ascertainable from the records of the licensee.

(ii) A public adjuster may commingle with such fiduciary funds in a particular account such additional funds as the adjuster deems prudent for payment of claims or for other contingencies arising in the adjusting business.

(iii) A public adjuster may commingle with the adjuster own funds those funds of a particular principal who has expressly waived the segregation requirement in writing and in advance.

(iv) Permitted commingling of the funds of others with the adjuster's funds shall not alter the fiduciary duties of the adjuster as to the others' funds.

[13.4.8.17 NMAC - N, 7/1/2019; A, 04/01/2025]

End of Adopted Rules

2024 New Mexico Register

Submittal Deadlines and Publication Dates

Volume XXXV, Issues 1-24

Issue	Submittal Deadline	Publication Date
Issue 1	January 4	January 16
Issue 2	January 18	January 30
Issue 3	February 1	February 13
Issue 4	February 15	February 27
Issue 5	February 29	March 12
Issue 6	March 14	March 26
Issue 7	March 28	April 9
Issue 8	April 11	April 23
Issue 9	April 25	May 7
Issue 10	May 9	May 21
Issue 11	May23	June 11
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Issue 19	September 26	October 8
Issue 20	October 10	October 22
Issue 21	October 24	November 5
Issue 22	November 7	November 19
Issue 23	November 26	December 10
Issue 24	December 12	December 23

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