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New Mexico Register

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A = Amended, E = Emergency, N = New, R = Repealed, Rn = Renumbered

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Notices of Rulemaking and Proposed Rules

TRANSPORTATION, DEPARTMENT OF

NOTICE OF EMERGENCY RULEMAKING

This is an emergency amendment to Rule 18.3.4 NMAC, Section 12, effective 12/23/2024.

To ensure the ongoing and continuous services needed to provide for the public health, safety and welfare of New Mexicans and visitors to our state, the New Mexico Department of Transportation (NMDOT) is undertaking an emergency rulemaking to revise the provisions of 18.3.4.12 NMAC, Section 12 to exempt ambulance service providers from requiring drivers be at least 21 years old.

As required by Senate Bill 160, which was passed by the legislature during the 2023 Legislative Session and signed into law on April 4, 2023, the Transportation Division of the New Mexico Public Regulation Commission (PRC) was transferred to the NMDOT effective July 1, 2024. As a result of this transfer, NMDOT became responsible for motor carrier regulation and enforcement, including ambulance standards.

Prior to the transfer, representatives from PRC and NMDOT worked collaboratively to position NMDOT to effectively and efficiently implement business processes and create new rules. On 7/1/2024, among other rules, following the normal rulemaking process, the NMDOT adopted 18.3.4.12 NMAC, Requirements Applicable Only to Non-CDL Drivers, which includes language require drivers of all regulated vehicles to be at least 21 years of age.

Very quickly following adoption of the rule, NMDOT received feedback from state agency partners and stakeholders of the motor carrier industry, particularly certificated ambulance service providers, that the new rule's requirements are cumbersome to them and will have a direct negative impact on the ability to meet the needs of New Mexico's citizens and visitors and would cause imminent peril to the public health, safety and welfare.

In a document dated September 9, 2024 ("DOT Regulation of Certified Ambulance Agencies; Identified Transition Issues"), the Department of Health's (DOH) Statewide Emergency Medical Services Advisory Committee (SWAC) clearly articulates its position on the rules:

The change in enforcement of existing rule, in addition to new rules, now in effect will significantly hinder ground ambulance provers' ability to operate. There is a high probability that prehospital emergency medical care will be unavailable for large areas of the geography of New Mexico due to particularly rural and frontier services being unable to comply with the published rules and enforcement.

Additionally, at its July 24, 2024 meeting, at least one of SWAC member articulated a concern that services to tribal communities would also be negatively impacted by the new rule.

The SWAC further indicates that New Mexico's Emergency Medical Services (EMS) infrastructure is staffed predominantly with volunteers, and that, "…individuals who work in EMS not only performed patient care in the back of the ambulance but are also required to drive. In order to obtain a position at a service, it is often a requirement that you be eligible to obtain licensure as an EMS provider in the State of New Mexico." To be licensed as an EMT Basic, the minimum age requirement is 17. While the requirements for ambulance drivers vary from state to state, the SWAC offers the following summary of its review of age requirements in 49 other states:

* 21 required drivers to be 18 years old and a valid driver's license2
* 16 listed no minimum age or driver requirements3
* 10 only required a "valid state issued driver's license"4
* 1 requires drivers to be 19 years old5 • 1 requires drivers to be 17 years old

In summary, as justification for and in support of this proposed emergency rulemaking, the DOH and the SWAC have very strongly articulated that applying this age requirement to ambulances:

* Is making it difficult to hire personnel or secure volunteers to provide needed EMS services;
* Would result in the loss of many current drivers, including volunteers, which leads to:
* A decrease or cessation of ambulance service, particularly in rural and tribal communities;
* A loss of jobs, including volunteer opportunities, for current drivers, who are under 21 years old;
* A loss of income for current drivers who are under 21 years old; and
* A negative economic impact on the communities in which current drivers who are under 21 reside.

This emergency rule is temporary pursuant to Section 14-4-5.6 NMSA 1978, State Rules Act, Emergency rule.

End of Notices of Rulemaking and Proposed Rules

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Adopted Rules

Effective Date and Validity of Rule Filings

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

EARLY CHILDHOOD EDUCATION AND CARE DEPARTMENT

The Early Childhood Education and Care Department has approved the repeal of 8.16.3 NMAC – REQUIREMENTS GOVERNING THE CHILD CARE FACILITY LOAN ACT, filed 09/14/2007 and replaced it with 8.9.9 NMAC - REQUIREMENTS GOVERNING THE CHILD CARE FACILITY LOAN ACT, adopted 12/23/2024 and effective 12/23/2024.

EARLY CHILDHOOD EDUCATION AND CARE DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 9 EARLY CHILDHOOD EDUCATION AND CARE
PART 9 REQUIREMENTS GOVERNING THE CHILD CARE FACILITY LOAN ACT

8.9.3.1 ISSUING AGENCY: Early Childhood Education and Care Department (ECECD).
[8.16.9.1 NMAC - Rp, 8.9.9.1 NMAC, 12/23/2024]

8.9.9.2 SCOPE: The Child Care Facility Loan Act fund program regulations shall apply to the use of funds by eligible applicants available pursuant to the Child Care Facility Loan Act, Sections 24-24-1 to 24-24-4 NMSA 1978.
[8.16.3.2 NMAC - Rp, 8.9.9.2 NMAC, 12/23/2024]

8.9.9.3 STATUTORY AUTHORITY: The regulations (rules) set forth herein, have been promulgated by the secretary of the New Mexico Early Childhood Education and Care Department, by authority of the Early Childhood Education and Care Department Act, Sections 9-29-1 to 9-29-13 NMSA 1978, and the Child Care Facility Loan Act, Sections 24-24-1 to 24-24-4 NMSA 1978, in conjunction with the New Mexico Finance Authority.
[8.16.3.3 NMAC – Rp, 8.9.9.3 NMAC, 12/23/2024]

8.9.9.4 DURATION: Permanent.
[8.16.3.4 NMAC - Rp, 8.9.9.4 NMAC, 12/23/2024]

8.9.9.5 EFFECTIVE DATE: December 23, 2024, unless a later date is cited at the end of a section.
[8.16.3.5 NMAC - Rp, 8.9.9.5 NMAC, 12/23/2024]

8.9.9.6 OBJECTIVE:

A. The objective of 8.16.3 NMAC is to establish standards and procedures for administering loans under the Child Care Facility Loan Act. The Child Care Facility Loan Act directs the Early Childhood Education and Care Department (the Department) in conjunction with the New Mexico Finance Authority (the Authority) to adopt rules to administer and implement the Child Care Facility Loan Act.

B. The Child Care Facility Loan Act creates the child care facility revolving loan fund to provide long-term, low-interest funding for loans to providers to make health and safety improvements and for operating capital to maintain adequate and appropriate environments for their clients.

C. These rules establish eligibility guidelines, loan application requirements and evaluation procedures for loan applications. The authority will adopt a separate policy governing the structuring and parameters (including interest rates and terms), and financial monitoring of loans from the child care facility revolving loan fund.
[8.16.3.6 NMAC - Rp, 8.9.9.6 NMAC, 12/23/2024]

8.9.9.7 DEFINITIONS:

A. "Act" means the Child Care Facilities Loan Act (Sections 24-24-1 to 24-24-4 NMSA 1978).

B. "Agreement" means the document or documents signed by the Authority and the eligible applicant that specifies the terms and conditions of a loan provided under the program.

C. "Applicant" means a provider which has filed an application for a loan with the department and the authority.

D. "Application" means a written document filed with the Department and the Authority by an applicant for the purpose of obtaining a loan. An application may include a form prescribed by the department and the authority, written responses to requests for information by the department and the authority, or another format as determined by the department and the authority.

E. "Authority" means the New Mexico Finance Authority.

F. "Authorized representative" means one or more individuals authorized by the governing body of an applicant to act on behalf of the applicant in connection with its application. An authorized representative may act on behalf of the applicant to the extent provided by law.

G. "Board" means the New Mexico Finance Authority

Board of Directors as created by the New Mexico Finance Authority Act, Sections 6-21-1 to 6-21-31 NMSA 1978.

H. "Department" means the New Mexico Early Childhood Education and Care Department.

I. "Facility" means a child care facility operated by a provider, including both family home-based and center-based programs, licensed by the department to provide care to infants, toddlers, and children.

J. "Fund" means the child care facility revolving loan fund held by the authority pursuant to the act.

K. "Loan" means a loan from the fund.

L. "Operating Capital" means funds needed to meet short-term obligations, such as accounts payable, wages, debt servicing, lease and income tax payments.

M. "Project" means health and safety improvements to a child care facility, including physical improvement, repair, maintenance, expansion and operation of a child care facility providing a healthy and safe teaching environment.

N. "Provider" means a person licensed by the department to provide child care to infants, toddlers and children pursuant to 8.9.4 NMAC.

O. "Rules" means these Child Care Facility Loan Act fund program regulations.

[8.16.3.7 NMAC - Rp, 8.9.9.7 NMAC, 12/23/2024]

8.9.9.8 ELIGIBILITY GUIDELINES FOR APPLICANTS AND PROJECTS:

A. An applicant is considered eligible if they meet the following eligibility requirements:

(1) is a provider as defined by the act and these rules; and is

(2) is verified as in good standing regarding its licensure by the department; and

(3) complies with all applicable federal, state and local laws and regulations.

B. A project is considered eligible if it meets the following eligibility requirements:

(1) is owned by an eligible applicant; and

(2) the project involves the physical improvement, repair, maintenance, expansion or operation of a facility, as defined by the act and these rules; and

(3) involves a facility licensed by the department under 8.9.4.11 NMAC; and

(4) is verified as supporting healthy and safe teaching environments by the department.

C. The department may give priority to eligible applicants that have facilities serving a proportionately high number of state-subsidized clients and low-income families (by statute, this factor has priority over all others) or based on other programmatic factors determined at discretion of the department.

[8.16.3.8 NMAC - Rp, 8.9.9.8 NMAC, 12/23/2024]

8.9.9.9 LOAN APPLICATION PROCEDURES:

A. Contingent upon a sufficient balance in the fund, the department and the authority will accept applications and award loans

B. The department and the authority will provide applications. Complete applications must be signed by an authorized representative of the provider. Only applications that are complete will be considered for a loan. The application shall include the following:

(1) evidence of the eligibility of the applicant and the project;

(2) proof of applicable licenses and certifications for the provider and the facility; and

(3) a detailed description of the circumstances that demonstrate the impact of the project, including a description of the need for child care services in the community in which the project is located, including data on licensed capacity and capacity to serve eligible children in the community.

(4) a description of how the project will benefit the health and safety of provider's clients; and provider's clients, the quality of the provider's program, or the operation of the facility; and number of state subsidized and low-income families total number of clients served;

(5) information on the current and proposed services of the applicant to state-subsidized clients and low-income families.

(6) a detailed description of the project to be financed, including:

(a) a description of the scope of work of the project;

(b) the estimated cost of the project;

(c) the target date for the initiation of the project and the estimated time to completion; and

(d) the estimated useful life of the project and selected components;

(7) a copy of the applicant's formation and governance documents (e.g., articles of incorporation and bylaws) identification of the source funds to complete the project if the loan requested is not sufficient to cover the full cost of the project;

(8) identification of the source of funds for repayment of the loan and the source of funds to operate and maintain the project over its useful life;

(9) the applicant's financial reports for the most recent three years and federal and state tax returns;

(10) the applicant's projected cash flows for at least 3 years;

(11) the applicant's business plan;

(12) the written assurance that the project is allowed by the owner of the facility, if the owner is not the applicant;

(13) any existing licenses or certifications that pertain to the business;

(14) any insurance documents pertaining to the business; and

(15) any additional information as requested by the department or authority.

[8.16.3.9 NMAC - Rp, 8.9.9.9 NMAC, 12/23/2024]

8.9.9.10 EVALUATION OF APPLICANT AND PROJECT:

A. Evaluations and determinations by department.

(1) Once an application is complete, the department will evaluate the applicant and the proposed project for eligibility and make a determination as to eligibility.

(2) If the department determines that an applicant is eligible, the department will determine the programmatic priority for each application.

(3) Upon completion of its evaluation of eligibility and determination of programmatic priority, the department will refer the applications to the authority.

B. Financing approval by the authority.

(1) Staff at the authority will perform an independent analysis of the financial feasibility of each application for a loan. In evaluating an application, staff of the authority will consider:

(a) the ability of the eligible applicant to secure financing from other sources;

(b) the terms of any other sources of funding;

(c) the applicant's ability to repay the loan; and

(d) the applicant's ability and agreement to satisfy any other requirements for approval of the loan as the authority requires by its policy or otherwise.

(2) Restrictions on loans:

(a) No more than twenty percent of the fund may be loaned to a single provider in a single project.

(b) Loans from the fund are to be made at an interest rate greater than zero.

(c) Loans from the fund are to be made for a term that does not exceed the useful life of the project being financed.

C. Approval by the authority. Staff of the authority may recommend applications for approval to the board. The board may approve all or part of any application recommended or may disapprove the application and deny funding at its sole discretion.

[8.16.3.10 NMAC - Rp, 8.9.9.10 NMAC, 12/23/2024]

8.9.9.11 RECONSIDERATION OF DECISIONS BY DEPARTMENT AND THE AUTHORITY:

A. Decision by department as to eligibility. An applicant may request reconsideration of a contrary decision by the department as to whether it is an eligible applicant under these regulations. Notice must be given to the department in writing within ten working days of receipt of the department's decision as to eligibility. A request for reconsideration not timely or properly made will be barred. The department's secretary or designee will promptly review each timely request for reconsideration. The decision of the department secretary or designee as to eligibility is final.

B. Decision by the authority as to financing. An applicant may request reconsideration of a decision by the authority denying a loan to an applicant by notifying the chief executive officer of the authority in writing within fifteen days of the date on which notice of an adverse decision is given by the authority to an applicant. The authority's chief executive officer will promptly review each timely request for reconsideration. The authority's chief executive officer will either consider the request for reconsideration or reject the appeal. The authority's chief executive officer will provide the applicant written notice of the rejection of a request for reconsideration within five business days following such decision. An applicant may appeal the authority's chief executive officer's decision by submitting a notice of appeal to the authority's board within 10 business days following receipt of the notice of that decision, which notice of appeal must include any reasons and documentation supporting the applicant's position. An applicant's appeal to the authority's board will be considered by the authority's board at its next regular meeting. The decision of the authority's board is final.

[8.16.3.11 NMAC - Rp, 8.9.9.11 NMAC, 12/23/2024]

8.9.9.12 LOAN AGREEMENTS:

A. The authority and the eligible applicant will enter into an agreement and any other applicable documentation to establish the terms and conditions of the loan from the authority. The agreement will include the terms of repayment and sanctions available to the authority in the event of a default.

B. The agreement will contain provisions that require loan recipients to comply with all applicable federal, state and local laws and regulations.

C. The agreement will contain a provision that the eligible applicant agrees that any contract or subcontract executed for the completion of any project shall contain a provision that there shall be no discrimination against any employee or applicant for employment because of race, color, creed, sex, religion, sexual preference, ancestry or national origin. The authority shall not be responsible for monitoring the contracts or subcontracts for inclusion of that provision or compliance with it.

D. The authority will monitor the financial covenants of the agreement and will enforce all terms

and conditions thereof, including prompt notice and collection. The authority will take actions as necessary to ensure loan repayment and the integrity of the fund.

E. The department will monitor the performance of an eligible applicant under department licensure requirements and for programmatic requirements and will make the necessary site visits. The authority will not monitor the performance of an eligible applicant under department licensure requirements nor for programmatic requirements and will not make site visits. The authority will not be responsible for any act or omission of the applicant upon which any claim, by or on behalf of any person, firm, corporation or other legal entity, may be made, arising from the loan or any establishment or modification of the project or otherwise. The department will promptly notify the authority if a loan recipient falls out of compliance with any licensure or programmatic requirements.

F. In the event the loan recipient defaults, the authority may enforce its rights by suit or mandamus and may utilize all other available remedies under state and federal law.

G. If an eligible applicant that has received a loan ceases to maintain its provider status or ceases to provide child care to infants, toddlers and children, the state shall have the following remedies available to it:

(1) the acceleration of the loan requiring the immediate repayment of all amounts due, including all accrued and unpaid interest;

(2) any other remedies available at law or in equity.

[8.16.3.12 NMAC - Rp, 8.9.9.12 NMAC, 12/23/2024]

8.9.9.13 ADMINISTRATION OF THE FUND:

A. The fund is created in the authority consisting of appropriations, gifts, grants and donations to the fund, which shall be invested as provided in the New Mexico Finance Authority Act.

B. Money in the fund shall not revert.

C. Administrative costs of the authority may be paid from the fund.

D. The fund shall be administered by the authority as a separate account, but may consist of such sub-accounts as the authority deems necessary to carry out the purposes of the fund.

E. Money from repayments of loans or payments on securities held by the authority for projects authorized specifically by law shall be deposited in the fund. The fund shall also consist of any other money appropriated, distributed or otherwise allocated to the fund for the purpose of financing projects authorized specifically by law.

[8.16.3.13 NMAC - Rp, 8.9.9.13 NMAC, 12/23/2024]

HISTORY OF 8.16.3 NMAC:

History of Repealed Material:
8.16.3 NMAC, Requirements Governing the Child Care Facility Loan Act, filed 2/15/2005 - Repealed effective 10/17/2005.
8.16.3 NMAC, Requirements Governing the Child Care Facility Loan Act, filed 10/3/2005 - Repealed effective 9/14/2007.
8.16.3 NMAC, Requirements Governing the Child Care Facility Loan Act, filed 10/3/2005 - Repealed effective 12/23/2024.

FINANCE AND ADMINISTRATION, DEPARTMENT OF
STATE BOARD OF FINANCE

The State Board of Finance approved the repeal of 1.5.23 NMAC - Real Property Acquisitions, Sales, Trades, or Leases on 1/19/2001 and replaced it with 1.5.23 NMAC - Real Property Acquisitions, Sales, Trades, or Leases, adopted on 11/19/2024 and effective 12/23/2024.

The State Board of Finance approved the repeal of 2.70.4 NMAC - Policy on Capital Expenditures by State Educational Institutions filed on 1/17/2007 and replaced it with 2.70.4 NMAC - Policy on Capital Expenditures by State Educational Institutions, adopted on 11/19/2024 and effective 12/23/2024.

FINANCE AND ADMINISTRATION, DEPARTMENT OF
STATE BOARD OF FINANCE

TITLE 1 GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 5 PUBLIC PROPERTY MANAGEMENT
PART 23 REAL PROPERTY ACQUISITIONS, SALES, TRADES, OR LEASES

1.5.23.1 ISSUING AGENCY: State Board of Finance, 181 Bataan Memorial Building, Santa Fe, NM.
[1.5.23.1 NMAC - Rp, 1.5.23.1 NMAC 12/23/2024]

1.5.23.2 SCOPE: Any transfer of funds, capital outlay project, or acquisition, donation to, or purchase, sale, trade or lease or other disposition of real property by public bodies that by law requires state board of finance approval, except as otherwise indicated, or unless already addressed in a separate board rule.
[1.5.23.2 NMAC - Rp, 1.5.23.2 NMAC 12/23/2024]

1.5.23.3 STATUTORY AUTHORITY:

A. Section 13-6-2.1 NMSA 1978 provides generally, with certain exceptions, that any state agency, local public body, or school district that sells, trades or leases real property belonging to that public entity requires state board of finance approval prior to the effective date of such sale, trade or lease. Section 16-6-15, NMSA 1978, makes Section 13-6-2.1 NMSA 1978 expressly applicable to the state fair.

B. Sections 15-3B-8 NMSA 1978 provide that the property control division is authorized to

acquire land by purchase, gift or donation subject to prior approval by the state board of finance.

C. Subsection B of Section 15-3B-7 NMSA 1978 provides that the property control division, subject to the approval of the state board of finance and after following the bidding procedures required by the Procurement Code for the purchase of personal tangible property, is authorized to enter into long-term leases not exceeding 10 years of vacant lands when the lessor contracts with the state to construct and complete buildings, subject to approval of the state architect, as a condition precedent to the start of the rental term.

D. Section 17-1-22.1 NMSA 1978 provides that the state game commission, upon approval from the state board of finance, may transfer money from the game and fish bond retirement fund to the game and fish capital outlay fund. Money in the game and fish capital outlay fund may be expended for fish hatcheries and rearing facilities, habitat acquisition, development and improvements and other similar capital projects. All projects funded by the game and fish capital outlay fund shall be approved by the state board of finance.

E. Subsection B of Section 3-46-34 NMSA 1978 provides that a municipality may dispose of real property in an urban renewal or land development area to private persons only under reasonably competitive bidding procedures as it shall prescribe or as provided in this subsection. The municipality may accept any proposal it deems to be in the best interest and in furtherance of the purposes of the urban renewal law; provided, that a notification of intention to accept the proposal shall be filed with the governing body not less than thirty days prior to any acceptance. Thereafter, the municipality may execute a contract in accordance with the provisions of the urban renewal law, and deliver deeds, leases and other instruments and take all steps necessary to effectuate the contract; provided that if the municipality accepts other than the highest bid, the acceptance must be approved by the state board of finance before the municipality may proceed.

F. Subsection J of Section 16-2-11 NMSA 1978 provides that any acquisition of lands adjacent or contiguous to existing state parks or recreational areas or necessary for successful park or recreational area protection and development and will become part of the park or recreational area may be acquired by the state following consultation with local government entities on the acquisition and approval of the acquisition by the state board of finance, and funds for acquisition is available to state parks division or land is being donated to the division.

[1.5.23.3 NMAC - Rp, 1.5.23.3 NMAC 12/23/2024]

1.5.23.4 DURATION: Permanent.

[1.5.23.4 NMAC - Rp, 1.5.23.4 NMAC 12/23/2024]

1.5.23.5 EFFECTIVE DATE: December 23, 2024, unless a later date is cited at the end of a section.

[1.5.23.5 NMAC - Rp, 1.5.23.5 NMAC 12/23/2024]

1.5.23.6 OBJECTIVE: This rule provides general guidance regarding the financial and legal requirements for state board of finance approval of certain real property transactions as required by state statute. This rule is not applicable to the acquisition of real estate by Article XII, Section 11 educational institutions, whose expenditures regarding acquisitions are governed by a separate board rule. The rule is intended to benefit the state and its agencies and political subdivisions in their real property dealings by describing which transactions require state board of finance approval and listing materials that must be submitted to the state board of finance for approval. State board of finance approval is based solely on information provided by the public body. The state board of finance has no duty to independently investigate, and does not independently investigate, the merits and risks involved in the real property transaction.

[1.5.23.6 NMAC - Rp, 1.5.23.6 NMAC 12/23/2024]

1.5.23.7 DEFINITIONS:

A. "Acquisition" means, unless usage indicates otherwise, obtaining title in fee simple absolute to real estate by purchase, trade, gift or donation.

B. "Appraisal report" means a report of an opinion of value conducted by a general certified appraiser and that meets all requirements under the Uniform Standards of Professional Appraisal Practice (USPAP).

C. "Board" means state board of finance.

D. "Consideration" means something which is of a value at least equal to the value of the real property interest being conveyed, including but not limited to cash, another piece of real estate, services, or other form of compensation.

E. "Current" means:

(1) in the context of an appraisal, an appraisal report with an effective date within one year of the date of submission of the proposed transaction to the board for approval, and

(2) in the context of a title binder, dated within six months of the proposed closing date.

F. "General certified appraiser" means a person who holds a valid, current general certificate as a state certified real estate appraiser issued by the real estate appraisers board pursuant to the Real Estate Appraisers Act.

G. "Local public body" means all political subdivisions, but not including municipalities except for those transactions where board approval is required by law and school districts, of the state and their agencies, instrumentalities and institutions.

H. "Private entity" means any non-public entity, including but not limited to persons, associations, and both for-profit and non-profit corporations. It does not include Indian nations, tribes and pueblos.

I. "Public entity" means a local public body, a state agency, a school district or state educational institution.

J. "Real property" means any interest in real estate, including but not limited to estates in fee simple, leaseholds (including subleaseholds and any leases entered into pursuant to Section 4-38-13.1 NMSA 1978), water rights and permanent easements.

K. "Residential certified appraiser" means a person who holds a valid, current residential certificate as a state certified real estate appraiser issued by the real estate appraisers board pursuant to the Real Estate Appraisers Act (who has met the qualification required in Subsection C of Sections 60-30-12 NMSA 1978 and 16.62.4.8 NMAC).

L. "Sale, trade or lease" means any disposition of real property, including but not limited to donations by one governmental entity to another governmental entity, but disposition does not include demolition of buildings or other improvements on real property owned by the public body.

M. "School district" means those political subdivisions of the state established for the administration of public schools.

N. "State agency" means the state of New Mexico or any of its branches, agencies, departments, boards, instrumentalities, or institutions other than state educational institutions.

O. "School districts" means those political subdivisions of the state established for the administration of public schools.

P. "State educational institution" means Article XII, Section 11 educational institutions.

Q. "Term" means the period of time during which a lease is in effect, and includes all renewal options or extensions.

[1.5.23.7 NMAC - Rp, 1.5.23.7 NMAC 12/23/2024]

1.5.23.8 ACQUISITION OF REAL PROPERTY:

A. Public bodies requiring board approval before acquiring real property include, but are not limited to, the following:

(1) general services department;

(2) department of game and fish for expenditures from the game and fish capital outlay fund;

(3) the state for state parks or recreational areas pursuant to Subsection J of Section 16-11 NMSA 1978.

B. In order to attain approval for acquisition of real property, the board requires that the following information be provided at the time of submission to the board:

(1) the form of general warranty deed by which the public entity will take title in fee simple absolute containing legal description of the property and warranty covenants; reversions or other forfeiture provisions in the deed shall be accepted only under extraordinary circumstances; special warranty deeds will be accepted only under extraordinary circumstances; when the seller is a public body, transfer of title shall be by quitclaim deed;

(2) a copy of a current appraisal report completed by a general certified appraiser for commercial property or a general certified appraiser or a residential certified appraiser for residential property and report of review from the property tax division of the taxation and revenue department if the appraisal was not done by the property tax division; the public entity seeking property tax division review must submit necessary information to the property tax division within the time frame specified by the property tax division; when the seller is another governmental entity, neither an appraisal nor property tax division review is required;

(3) full sized site improvement survey plat to verify legal description and to identify the existence of recorded easements and encroachments, if applicable;

(4) a description of the proposed use;

(5) sources of funds used for the purchase;

(6) current title binder evidencing clear title with no non-standard exceptions, and:

(a) agreement by the title company of the inclusion of exceptions and statements verbatim as set forth in 13.14.5.10 NMAC;

(b) for any special exceptions listed in Schedule B, an explanation of each exception and measures the public body is taking to mitigate any risks associated with the exception;

(7) purchase agreement, if applicable, containing a statement making the purchase and any amendments to the agreement subject to board approval;

(8) phase 1 environmental assessment for all properties; phase II environmental assessment if recommended by the phase I assessment; explanation of any recognized environmental conditions contained in such assessments and statement of how recognized environmental conditions will impact intended use of the property;

(9) resolution or minutes of the governing body, if applicable, authorizing the purchase and containing a provision making the acquisition subject to approval by the board; and

(10) approval of the disposition by the local government division of the department of finance and administration pursuant to Subsection D of Section 3-54-2 NMSA 1978 if the entity selling, exchanging or donating the real property is a municipality

C. Acquisition of real property for more than fair market value, as determined by the requirements of Paragraph (2) of

Subsection B of 1.5.23.8 NMAC, is not permitted.
[1.5.23.8 NMAC - Rp, 1.5.23.8 NMAC 12/23/2024]

1.5.23.9 SALE OR TRADE OF REAL PROPERTY:

A. If the sale or trade of real property is for a consideration of more than twenty-five thousand dollars ($25,000), then prior board approval is necessary for:

(1) state agencies (unless the consideration is one hundred thousand dollars ($100,000) or more, in which case require approval by the legislature is required);

(2) school districts; and

(3) local public bodies, including, but not limited to:

(a) counties;

(b) community colleges (but not including branch community colleges) and technical vocational institutes;

(c) conservancy districts; and

(d) flood control authorities.

B. In order to obtain approval for the sale or trade of real property, the board requires that the following information be provided at the time of submission to the board:

(1) any summary information, forms, or checklists as determined and required by board staff through established guidelines;

(2) a cover letter providing details of the request;

(3) the form of quitclaim deed from the public body transferring title to purchaser containing the legal description of the property;

(4) a copy of a current appraisal report completed by a general certified appraiser for commercial property or a general certified appraiser or a residential certified appraiser for residential property and report of review by the property tax division of the taxation and revenue department if the appraisal was not done by the property tax division (for both properties if trade); the public entity seeking property tax division review must submit necessary information to the property tax division within time frame specified by the property tax division; when the buyer is another governmental entity, neither an appraisal nor property tax division review is required;

(5) a description of the reason for the sale or trade;

(6) selection process used to determine purchaser; competitive sealed bid, public auction, or negotiation;

(7) purchase price and if applicable, cost per square foot, cost per acre, or cost per acre foot of water rights, etc. (for both properties if trade);

(8) sale agreement, if applicable, containing a statement making the sale or trade and any amendments to the agreement subject to board approval;

(9) resolution or minutes of the governing body, if applicable, authorizing the sale or trade and containing a provision making the sale or trade subject to approval by the board;

(10) approval by the state engineer of any transfer of water rights;

(11) if a school district is seeking approval of a disposition of real property that includes a building, it must submit evidence that the building does not meet public school capital outlay council occupancy standards or that all charter schools located in the district have declined within a reasonable period of time set by the school district, use of the building pursuant to Subsection F of Section 22-8B-4 NMSA 1978; and

(12) if a state agency is seeking approval of the disposition of real property within the boundaries of a community land grant, a resolution or meeting minutes of the board of trustees of the community land grant evidencing its intent not to purchase the real property pursuant to Section 13-6-5 NMSA 1978; in the event a board of trustees does not respond to the state agency's notice of sale within forty-five days, the state agency shall document the lack of response in its submission to the board.

C. Transfer for less than fair market value, as determined by the requirements of Paragraph (2) of Subsection B of 1.5.23.9 NMAC, of real property owned by a public entity to any private entity is not permitted, except as authorized by legislation implementing the economic development and affordable housing exceptions to the Anti-donation Clause of Article IX, Section 14 of the New Mexico constitution.
[1.5.23.9 NMAC - Rp, 1.5.23.9 NMAC 12/23/2024]

1.5.23.10 LEASE OF REAL PROPERTY:

A. Board approval is required whenever certain public bodies wish to lease (or sub-lease) properties they own (or are leasing): if

(1) the term of the lease or sublease is for a period of more than five years, or

(2) the consideration over the lease term is more than twenty-five thousand dollars ($25,000).

B. Prior board approval is necessary for:

(1) state agencies (unless consideration is one hundred thousand dollars ($100,000) or more and the term is for a period of more than twenty-five years, in which case approval by the legislature is required);

(2) counties;

(3) school districts (unless leasing facilities to a locally chartered or state-chartered charter school, in which case approval by the public school facilities authority is required); and

(4) local public bodies, which include, but are not limited to, the following:

(a) community colleges (but not

including branch community colleges) and technical vocational institutes;

(b) conservancy districts;

(c) flood control authorities; and

(d) special hospital districts and county hospitals pursuant to the Hospital Funding Act.

C. In order to obtain approval for leases of real property, the board requires that at least the following information be provided:

(1) any summary information, forms, or checklists as determined and required by board staff through established guidelines;

(2) a cover letter providing details of the request;

(3) current appraisal report completed by a general certified appraiser for commercial property or a general certified appraiser or a residential certified appraiser for residential property or other evidence of fair market value and report of review from the property tax division of the taxation and revenue department if the appraisal was not done by the property tax division; the public entity seeking property tax division review must submit necessary information to the property tax division within the time frame specified by the property tax division; when the lessee/tenant is another public body, neither an appraisal nor property tax division review is required;

(4) copy of the lease containing a statement making the lease and any amendments subject to board approval;

(5) resolution from the governing body, if applicable, approving the lease, and containing a provision making the lease subject to board approval;

(6) the reason for leasing;

(7) description of the selection process used to determine lessee: competitive sealed bid, public auction, or negotiation;

(8) if consideration is being provided by the lessee (or sub-lessee), partially or completely, in the form of services, tangible personal property or construction, evidence that the selection of the lessee (or sub-lessee) complied with the procurement code or is expressly exempted and the term of the lease complies with, Section 13-1-150 NMSA 1978, as it may be amended from time to time;

(9) if a school district is seeking approval of a lease of real property that includes a building, evidence the building does not meet public school capital outlay council occupancy standards or that all charter schools located in the district have declined within a reasonable period of time set by the school district use of the building pursuant to Subsection F of Section 22-8B-4 NMSA 1978; and

D. Rent or other consideration at less than fair market value, as determined by the requirements of Paragraph (1) of Subsection B of 1.5.23.10 NMAC, from a private entity is not permitted, except as authorized by legislation implementing the economic development and affordable housing exceptions to the Anti-donation Clause of Article IX, Section 14 of the New Mexico constitution.
[1.5.23.10 NMAC - Rp, 1.5.23.10 NMAC 12/23/2024]

1.5.23.11 SUBMISSION OF REQUESTS TO THE STATE BOARD OF FINANCE:

A. Real property transaction requests submitted to the board should address each of the specific items in this rule, as applicable. An electronic bookmarked PDF must be submitted to the board.

B. Completed packages, in their entirety, must be submitted on or before the board's meeting deadline, as published on the board's website, and must meet application-formatting criteria.

C. Upon request, the board, in its discretion, may waive any requirement under this rule provided that the requesting party can demonstrate that other documents provided are equivalent to or satisfy the rationale for submitting the item and that the state's interest will still be sufficiently protected.

D. The board, in its discretion, may require additional information be provided as may be relevant to a specific transaction.
[1.5.23.11 NMAC - Rp, 1.5.23.11 NMAC 12/23/2024]

HISTORY OF 1.5.23 NMAC Pre-NMAC History: none.

History of Repealed Material:
1.5.23 NMAC, Real Property Acquisitions, Sales, Trades, or Leases filed 1/19/2001 Repealed effective 12/23/2024.

Other: 1.5.23 NMAC, Real Property Acquisitions, Sales, Trades, or Leases filed 1/19/2001 Replaced by 1.5.23 Real Property Acquisitions, Sales, Trades, or Leases effective 12/23/2024.

FINANCE AND ADMINISTRATION, DEPARTMENT OF
STATE BOARD OF FINANCE

TITLE 2 PUBLIC FINANCE
CHAPTER 70 CAPITAL EXPENDITURES
PART 4 POLICY ON CAPITAL EXPENDITURES BY STATE EDUCATIONAL INSTITUTIONS

2.70.4.1 ISSUING AGENCY: State Board of Finance.
[2.70.4.1 NMAC - Rp, 2.70.4.1 NMAC 12/23/2024]

2.70.4.2 SCOPE: All institutions of higher education confirmed by Article 12, Section 11 of the New Mexico Constitution.
[2.70.4.2 NMAC - Rp, 2.70.4.2 NMAC 12/23/2024]

2.70.4.3 STATUTORY AUTHORITY: Section 21-1-21, NMSA 1978, as amended, which requires prior approval by the higher education department and state board

of finance of any expenditure by any state educational institution confirmed by Article 12, Section 11 of the state constitution for the purchase of real property or construction of buildings or other major structures or major remodeling projects. Section 21-1-21.1, NMSA 1978, as amended, which requires evidence of adequate parking. Executive Order 2006-001, which establishes energy efficiency green building standards for state of New Mexico executive buildings, including the higher education department.
[2.70.4.3 NMAC - Rp, 2.70.4.3 NMAC 12/23/2024]

2.70.4.4 DURATION: Permanent.
[2.70.4.4 NMAC - Rp, 2.70.4.4 NMAC 12/23/2024]

2.70.4.5 EFFECTIVE DATE: December 23, 2024, unless a later date is cited at the end of a section.
[2.70.4.5 NMAC - Rp, 2.70.4.5 NMAC 12/23/2024]

2.70.4.6 OBJECTIVE:

A. Section 21-1-21 NMSA 1978 states: "No expenditure shall be made by any state educational institution confirmed by Article 12, Section 11 of the state constitution for the purchase of real property or the construction of buildings or other major structures or for major remodeling projects without prior approval of the proposed purchase or construction or remodeling by the board of educational finance and the state board of finance".

B. Involvement of the state board of finance in the approval of capital outlay projects and capital expenditures at New Mexico colleges and universities is specified by this statute. This involvement is substantially different from the involvement with state building projects, where the state board of finance is the final authority for accepting bids and determining whether the project will be constructed. In the case of educational institutions, the authority for the actual construction of the project resides with the board of regents of the institution. However, New Mexico statute requires the higher education department and the state board of finance to provide prior approval to the board of regents before they are allowed to proceed with the project.

C. Since the statute requires the higher education department and the state board of finance to provide "prior" approval of the project, these two bodies should review all major capital projects to determine that the proposed project is in keeping with the overall statewide plan for higher education. The source of funding for the project should also be carefully reviewed to determine that sufficient funds are available for the project and the use of the funds will not have an adverse effect on other portions of the institution's budget. The sufficiency of planning for the project, and the completeness of the review of the project by the board of regents should also be determined.
[2.70.4.6 NMAC - Rp, 2.70.4.6 NMAC 12/23/2024]

2.70.4.7 DEFINITIONS: For these purposes, "major" is defined as:

A. "Appraisal report" for the purpose of real property purchases means a report of an opinion of value conducted by a general certified appraiser and that meets all requirements under the Uniform Standards of Professional Appraisal Practice (USPAP).

B. "Board" means the state board of finance.

C. "Current" means:

(1) in the context of a title binder dated within six months of the proposed closing date;

(2) in the context of an appraisal an appraisal report with an effective date within one year of the date of submission of the proposed transaction to the board for approval.

D. "Equipment costs" for the purpose of construction or remodeling are defined as costs for equipment, machinery, apparatus, appliances, furniture, and fixtures, either moveable or non-moveable.

E. "Major" for the purpose of remodeling projects is defined as any project meeting the cost thresholds established in this subparagraph E so long as equipment costs do not exceed fifty percent of the total project cost.

(1) any project funded, in whole or in part, by capital outlay legislation signed into law for which costs exceed $1,600,000.00, at institutions with FTE enrollments under 1,500;

(2) any project funded, in whole or in part, by capital outlay legislation signed into law for which costs exceed $2,400,000.00, at institutions with FTE enrollments of 1,500 or more;

(3) any project funded exclusively by sources other than legislative appropriations for which costs exceed $160,000.00, at institutions with enrollments of 1,500 FTE or less; or

(4) any project funded exclusively by sources other than legislative appropriations for which costs exceed $950,000.00, at institutions with enrollments exceeding 1,500 FTE.

F. "Public entity" means a local public body, a state agency, a school district, a state educational institution, or other governmental instrumentality created by statute.

G. "Remodel" means to change, modify, or transform a space in a way that alters its use, design, or function, including the reconfiguration of spaces. Remodel encompasses renovation and repair when the use, design, or function of a space is altered.

H. "Renovation" means the change, strengthening, or addition of load-bearing elements; or the refinishing, replacement, bracing, strengthening, upgrading, or extensive repair of existing materials, elements, components, equipment or fixtures. To revive, restore, or repair an existing space.

I. "Repair" means the reconstruction, replacement, or renewal of any part of an existing building for the purpose of its maintenance or to correct damage. Repair may include infrastructure systems replacements (e.g., elevators, roofs, HVAC, signage, stucco, windows, lighting, electrical, plumbing, flooring).

[2.70.4.7 NMAC - Rp, 2.70.4.7 NMAC 12/23/2024]

2.70.4.8 PROJECTS REQUIRING REVIEW:

A. All projects that fall under the following categories must be submitted for review by the state board of finance:

(1) any purchase of real property;

(2) any construction of a new building;

(3) any project involving a bond issue which requires state board of finance approval;

(4) any other major project, including construction of facilities such as parking lots or radio towers; site improvements or landscaping; and remodeling of an existing building, but not demolition unless part of a larger project that requires approval.

B. In-house labor applied to a project must be included as part of the cost of the project. Projects may not be artificially segmented or phased in a manner designed to avoid review by the state board of finance.

[2.70.4.8 NMAC - Rp, 2.70.4.8 NMAC 12/23/2024]

2.70.4.9 INFORMATION REQUIRED FOR SUBMISSION FOR PURCHASE OF REAL PROPERTY:

A. To ensure that the state board of finance will have sufficient information to review capital expenditures at New Mexico's educational institutions, the following information must be submitted to the board after the higher education department has approved the request:

(1) legal description of the property;

(2) a copy of a current appraisal report completed by a general certified appraiser for commercial property or a general certified appraiser or a residential certified appraiser for residential property and report of review from the property tax division of the taxation and revenue department if the appraisal was not done by the property tax division; the educational institution seeking property tax division review must submit necessary information to the property tax division within the time frame specified by the property tax division; when the seller is another governmental entity, neither an appraisal nor property tax division review is required;

(3) a site improvement survey to verify the legal description and to uncover the existence of recorded and unrecorded easements and encroachments;

(4) a description of the use to which the property will be placed;

(5) the source of funds for the purchase to include citation of the relevant section of the law when source of funds is legislative appropriation and in the case of bond funding, representation that bond proceeds are available;

(6) current title binder in the form required by 13.14.5 NMAC evidencing clear title, including all required statements. For any special exceptions listed in Schedule B, the public body shall provide an explanation of each exception and measures it is taking to mitigate any risks associated with the exception;

(7) the form of general warranty deed by which the educational institution will take title in fee simple absolute containing a legal description of the property and warranty covenants; when the seller is another governmental entity, transfer of title shall be by quitclaim deed;

(8) phase I of an environmental assessment to verify prior use of the land with regard to possible environmental hazards;

(9) a copy of the purchase agreement containing a provision making the purchase subject to the approval of higher education department and the state board of finance; and

(10) evidence of approval of the purchase by the applicable state educational institution's governing board and the higher education department.

B. Waivers of certain provisions may be granted at the discretion of the board of finance, on a case by case basis,

C. Requirements affecting bond approvals are set forth in 2.61.5 NMAC.

[2.70.4.9 NMAC - Rp, 2.70.4.9 NMAC 12/23/2024]

2.70.4.10 INFORMATION REQUIRED FOR SUBMISSION FOR CONSTRUCTION OF BUILDINGS OR OTHER FACILITIES; MAJOR REMODELING:

A. To ensure that the state board of finance will have sufficient information to review capital expenditures at New Mexico's educational institutions, the following must be submitted to the board after the higher education department has approved the request:

(1) a description of the facility to be constructed or remodeled, including the types of space to be included, the function of the facility, and the relationship of the project to the institution's five-year master plan;

(2) the total square footage of the facility, both net assignable square feet and gross square feet;

(3) the cost per square foot for the construction or remodel of the facility and the cost per square foot for the total project;

(4) a budget for the project, including equipment costs, architect and engineering fees and contingencies;

(5) source of funds to include citation of the relevant section of the law when source of funds is legislative

appropriation and in the case of bond funding, representation that bond proceeds are available;

(6) certificate of adequate parking as required in Section 21-1-21.1, NMSA 1978, as amended;

(7) evidence of approval of expenditure by applicable board of regents and higher education department;

(8) evidence of approval by higher education department and the energy, minerals, and natural resources department of the following criteria as it may be amended from time to time:

(a) certification and demonstration of compliance with all commercial energy conservation requirements as set forth in 14.7.9 NMAC. Certification and demonstration means showing of qualifications or attributes that comply with or meet the specified requirements or standards set forth in 14.7.9 NMAC by either officially attesting to or authoritatively confirming through review by the energy, minerals, and natural resources department or the higher education department; and

(b) if the facility is less than or equal to 5,000 square feet, evidence of energy efficient measures;

(c) if the facility is greater than 5,000 square feet and less than or equal to 15,000 square feet, evidence of fifty percent reduction in energy use compared to existing facilities of similar type as defined by the United States department of energy; or

(d) if the facility is greater than 15,000 square feet, evidence of fifty percent reduction in energy use compared to existing facilities of similar type as defined by the United States department of energy and the achievement of a LEED silver rating or better.

B. Waivers of certain provisions may be granted at the discretion of the board of finance, on a case by case basis.

C. Requirements affecting bond approvals are set forth in 2.61.5 NMAC.

[2.70.4.10 NMAC - Rp, 2.70.4.10 NMAC 12/23/2024]

2.70.4.11 REVISED PROJECTS: To ensure that the project actually constructed will be substantially the same as that approved by the higher education department and the state board of finance, any change in the project resulting in a change in the budget of more than ten percent will require separate review and approval by the state board of finance. The same information will be required for such changes as is required for the original submission of the project. Any additional information which can help in evaluating a proposed project can be requested by the state board of finance prior to approval.

[2.70.4.11 NMAC - Rp, 2.70.4.11 NMAC 12/23/2024]

HISTORY OF NMAC 2.70.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives: Directive 89-4, Policy on Capital Expenditures by State Educational Institutions, 8/30/1989.

History of Repealed Material:

2.70.4 NMAC, Policy on Capital Expenditures by State Educational Institutions filed 1/17/2007 Repealed effective 12/23/2024.

Other: 2.70.4 NMAC, Policy on Capital Expenditures by State Educational Institutions filed 1/17/2007 Replaced by 2.70.4 NMAC, Policy on Capital Expenditures by State Educational Institutions effective 12/23/2024.

HEALTH CARE AUTHORITY

MEDICAL ASSISTANCE DIVISION

This is an emergency amendment to 8.310.2 NMAC, Sections 8 and 12, effective 1/1/2025.

8.310.2.8 MISSION STATEMENT: [~~To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.~~] We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.

[8.310.2.8 NMAC - Rp, 8.310.2.8 NMAC, 1/1/2014; A, 8/10/2021; A/E, 1/1/2025]

8.310.2.12 SERVICES: MAD covers services and procedures that are medically necessary for the diagnosis and treatment of an illness or injury as indicated by the MAP eligible recipient's condition. All services must be furnished within the limits of provider program rules and within the scope of their practice board and licensure.

A. Medical practitioner services:

(1) Second surgical opinions: MAD covers second opinions when surgery is considered.

(2) Services performed in an outpatient setting: MAD covers procedures performed in the office, clinic or as outpatient institutional services as alternatives to hospitalization. These procedures are those for which an overnight stay in a hospital is seldom necessary.

(a) A MAP eligible recipient may be hospitalized if they have existing medical conditions that predispose them to complications even with minor procedures.

(b) Claims may be subject to pre-payment or post-payment review.

(c) Medical justification for performance of these procedures in a hospital must be documented in the MAP eligible recipient's medical record.

(3) Noncovered therapeutic radiology and diagnostic imaging services: MAD does not pay for kits, films or supplies as separate charges. All necessary materials and minor services are included in the service or procedure charge. Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. MAD does not pay an additional amount for contrast media except in the following instances:

(a) radioactive isotopes;

(b) non-ionic radiographic contrast material; or

(c) gadolinium salts used in magnetic resonance imaging.

(4) Midwives services: MAD covers services furnished by certified nurse midwives or licensed midwives within the scope of their practice, as defined by state laws and rules and within the scope of their practice board and licensure. Reimbursement for midwife services is based on one global fee, which includes prenatal care, delivery and postpartum care.

(a) Separate trimesters completed and routine vaginal delivery can be covered if a MAP eligible recipient is not under the care of one provider for the entire prenatal, delivery and postpartum periods.

(b) MAD covers laboratory and diagnostic imaging services related to pregnancy. These services can be billed separately.

(c) MAD covers gynecological or obstetrical ultrasounds without requiring a prior authorization of any kind.

(d) MAD covers a MAP eligible pregnant recipient's labor and delivery services at a New Mexico department of health (DOH) licensed birth center through the "Birthing Options Program" (BOP). MAD reimburses the birth center facility and the rendered services of a midwife separately. BOP services are provided by an eligible midwife that enrolls as a BOP provider with the human services department/medical assistance division (HSD/MAD). The facility must comply with all DOH licensing requirements, including limiting licensure. The facility must maintain all clinical documentation, including schedules, for the period of time as required under 8.302.1 NMAC. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

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

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

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

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

B. Pharmaceutical, vaccines and other items obtained from a pharmacy: MAD does not cover drug items that are classified as ineffective by the food and drug administration (FDA) and antitubercular drug items that are available from the public health department. In addition, MAD does not cover personal care items or pharmacy items used for cosmetic purposes only. Transportation to a pharmacy is not a MAD allowed benefit with the exception for justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release.

C. Laboratory and diagnostic imaging services: MAD covers medically necessary laboratory and diagnostic imaging services ordered by primary care provider (PCP), physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialists (CNS) and performed in the office by a provider or under his or her supervision by a clinical laboratory or a radiology laboratory, or by a hospital-based clinical laboratory or radiology laboratory that are a enrolled MAD provider. See 42 CFR Section 440.30.

(1) MAD covers interpretation of diagnostic imaging with payment as follows: when diagnostic radiology procedures, diagnostic imaging, diagnostic ultrasound, or non-invasive peripheral vascular studies are performed in a hospital inpatient or outpatient setting, payment is made only for the professional component of the service. This limitation does not apply if the hospital does not bill for any component of the radiology procedures and does not include the cost associated with furnishing these services in its cost reports.

(2) A provider may bill for the professional components of imaging services performed at a hospital or independent radiology laboratory if the provider does not request an interpretation by the hospital radiologist.

(3) Only one professional component is paid per radiological procedure.

(4) Radiology professional components are not paid when the same provider or provider group bills for professional components or interpretations and for the performance of the complete procedure.

(5) Professional components associated with clinical laboratory services are payable only when the work is actually performed by a pathologist who is not billing for global procedures and the service is for anatomic and surgical pathology only, including cytopathology,

histopathology, and bone marrow biopsies, or as otherwise allowed by the medicare program.

(6) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catheterization, unless a MAP eligible recipient is an inpatient of a nursing facility or hospital.

(7) **Noncovered laboratory services:** MAD does not cover laboratory specimen handling, mailing, or collection fees. Specimen collection is covered only if the specimen is drawn by venipuncture, arterial stick, or collected by urethral catheterization from a MAP eligible recipient who is not a resident of a NF or hospital. MAD does not cover the following specific laboratory services:

(a) clinical laboratory professional components, except as specifically described under covered services above;

(b) specimens, including pap smears, collected in a provider's office or a similar facility and conveyed to a second provider's office, office laboratory, or non-certified laboratory;

(c) laboratory specimen handling or mailing charges;

(d) specimen collection fees other than those specifically indicated in covered services; and

(e) laboratory specimen collection fees for a MAP eligible recipient in NF or inpatient hospital setting.

D. Reproductive health services: MAD pays for family planning and other related health services (see 42 CFR Section 440.40(c)) and supplies furnished by or under the supervision of a MAD enrolled provider acting within the scope of their practice board or licensure.

(1) Prior to performing medically necessary surgical procedures that result in sterility, providers must complete a "*sterilization consent*" or a "*hysterectomy acknowledgment/ consent*" form. MAD covers a medically necessary sterilization under the following conditions. See 42 CFR Section 441.251 et seq:

(a) a MAP eligible recipient 21 years and older at the time consent is obtained;

(b) a MAP eligible recipient is not mentally incompetent; mentally incompetent is a declaration of incompetency as made by a federal, state, or local court; a MAP eligible recipient can be declared competent by the court for a specific purpose, including the ability to consent to sterilization;

(c) a MAP eligible recipient is not institutionalized; for this section, institutionalized is defined as:

(i) an individual involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or an intermediate care facility for the care and treatment of mental illness;

(ii) confined under a voluntary commitment in a psychiatric hospital or other facility for the care and treatment of mental illness;

(d) a MAP eligible recipient seeking sterilization must be given information regarding the procedure and the results before signing a consent form; this explanation must include the fact that sterilization is a final, irreversible procedure; a MAP eligible recipient must be informed of the risks and benefits associated with the procedure;

(e) a MAP eligible recipient seeking sterilization must also be instructed that their consent can be withdrawn at any time prior to the performance of the procedure and that they would not lose any other MAD benefits as a result of the decision to have or not have the procedure; and

(f) a MAP eligible recipient voluntarily gives informed consent to the sterilization procedure. See 42 CFR Section 441.257(a); and

(g) a MAP eligible recipient's informed consent to the sterilization procedure must be attached to the claim.

(2) Hysterectomies: MAD covers only a medically necessary hysterectomy. MAD does not cover a hysterectomy performed for the sole purpose of sterilization. See 42 CFR Section 441.253.

(a) Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by the MAP eligible recipient prior to the operation.

(b) Acknowledgement of the sterilizing results of the hysterectomy is not required from a MAP eligible recipient who has been previously sterilized or who is past child-bearing age as defined by the medical community. In this instance, the PCP signs the bottom portion of the hysterectomy form which states the MAP eligible recipient has been formerly sterilized, and attaches it to the claim.

(c) An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.

(3) Birthing options services (BOP): MAD covers a MAP eligible pregnant recipient's labor and delivery services at a New Mexico department of health (DOH) licensed birth center through BOP. The BOP is an out-of-hospital birthing option for pregnant individuals enrolled in the medicaid program who are at low-risk for adverse birth outcomes. BOP services are provided by an eligible midwife that enrolls as a BOP provider with human services department/medical assistance division (HSD/MAD). The BOP services are specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover the full scope of midwifery services nor replace

pediatric care that should occur at a primary care clinic.

(4) Doula services: MAD covers doula services to prevent perinatal complication or promote the physical and mental health of the beneficiary. MAD covers only those services furnished by a doula certified by the department of health (DOH).

(a) Department of health certification of doula will include the following:

(i) a uniform application process with timelines and procedures;

(ii) a certification review committee; and

(iii) a uniform hearing process for which an applicant may appeal a decision by department of health.

(b) In addition to DOH certification eligible doula service providers must:

(i) be at least 18 years old;

(ii) maintain a current adult and infant cardiopulmonary resuscitation (CPR) certification from the American Red Cross or American Heart Association; and

(iii) complete the basic Health Insurance Portability and Accountability Act of 1996 (HIPPA) training.

(c) Doula services include the following:

(i) prenatal and post-partum physical, emotional, and evidence-based education support and linkages to community-based resources;

(ii) non-medical labor and delivery (L&D) support; and

(iii) education related to pre-conception, pregnancy loss, infant loss, or termination of pregnancy.

[~~(4)~~] **(5)** Other covered services: MAD covers medically necessary methods, procedures, pharmaceutical supplies and devices to prevent unintended pregnancy or contraception.

[~~(5)~~] **(6)** Noncovered reproductive health care: MAD does not cover the following specific services:

(a) sterilization reversal services;

(b) fertility drugs;

(c) in vitro fertilization;

(d) artificial insemination;

(e) hysterectomies performed for the sole purpose of family planning;

(f) induced vaginal deliveries prior to 39 weeks unless medically indicated;

(g) caesarean sections unless medically indicated; and

(h) elective procedures to terminate a pregnancy.

E. Nutritional services: MAD covers medically necessary nutritional services which are based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the MAP eligible recipient. MAD covers only those services furnished by PCP, licensed nutritionists or licensed dieticians. MAD covers the following services:

(1) Nutritional assessments for a pregnant MAP eligible recipient and for a MAP eligible recipient under 21 years of age through the early and periodic screening, diagnosis and treatment (EPSDT) program. Nutritional assessment is defined as an evaluation of the nutritional needs of the MAP eligible recipient based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs and includes recommending appropriate nutritional intake.

(2) Nutrition counseling to or on behalf of a MAP eligible recipient under 21 years of age who has been referred for a nutritional need. Nutrition counseling is defined as advising and helping a MAP eligible recipient obtain appropriate nutritional intake by integrating information from the nutrition assessment with information on food, other sources of nutrients and meal preparation, consistent with cultural background and socioeconomic status.

(3) Noncovered nutritional services: MAD covers only those services furnished by a PCP, licensed nutritionist or licensed dietician. MAD does not cover the following specific services:

(a) services not considered medically necessary for the condition of the MAP eligible recipient as determined by MAD or its designee;

(b) dietary counseling for the sole purpose of weight loss;

(c) weight control and weight management programs; and

(d) commercial dietary supplements or replacement products marketed for the primary purpose of weight loss and weight management; see 8.324.4 NMAC.

F. Transplant services: Non-experimental transplant services are covered. MAD covered transplantation services include hospital, a PCP, laboratory, outpatient surgical, and other MAD covered services necessary to perform the selected transplantation for the MAP eligible recipient and donor.

(1) Due to special medicare coverage available for individuals with end-stage renal disease, medicare eligibility must be pursued by the provider for coverage of a kidney transplant before requesting MAD reimbursement.

(2) MAD covers the MAP eligible recipient's and donor's related medical, transportation, meals and lodging services for non-experimental transplantation.

(3) MAD does not cover transplant procedures, treatments, use of a drug, biological product, a product or a device

which are considered unproven, experimental, investigational or not effective for the condition for which they are intended or used.

(4) A written prior authorization must be obtained for any transplant, with the exception of a cornea and a kidney. The prior authorization process must be started by the MAP eligible recipient's attending PCP contacting the MAD UR contractor. Services for which prior approval was obtained remain subject to UR at any point in the payment.

G. Dental services: Dental services are covered as an optional medical service for a MAP eligible recipient. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the MAP eligible recipient. See 42 CFR Section 440.100(a). MAD also covers dental services, dentures and special services for a MAP eligible recipient who qualifies for services under the EPSDT program. See 42 CFR Section 441.55.

(1) Emergency dental care: MAD covers emergency care for all MAP eligible recipients. Emergency care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection. For a MAP eligible recipient under 21 years of age, care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(a) Routine restorative procedures and root canal therapy are not emergency procedures.

(b) Prior authorization requirements are waived for emergency care, but the claim can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

(2) Diagnostic services: MAD coverage for diagnostic services is limited to the following:

(a) for a MAP eligible recipient under 21 years of age, diagnostic services are limited to one clinical oral examination every six months and upon referral one additional clinical oral examination by a different dental provider every six months;

(b) one clinical oral examination every 12 months for a MAP eligible recipient 21 years and older; and

(c) MAD covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.

(3) Radiology services: MAD coverage of radiology services is limited to the following:

(a) one intraoral complete series every 60 months per MAP eligible recipient; this series includes bitewing x-rays;

(b) additional bitewing x-rays once every 12 months per MAP eligible recipient; and

(c) panoramic films performed can be substituted for an intraoral complete series, which is limited to one every 60 months per MAP eligible recipient.

(4) Preventive services: MAD coverage of preventive services is subject to certain limitations.

(a) Prophylaxis: MAD covers for a MAP eligible recipient under 21 years of age one prophylaxis service every six months. MAD covers for a MAP eligible recipient 21 years of age and older who has a developmental disability, as defined in 8.314.6 NMAC, one prophylaxis service every six months. For a MAP eligible recipient 21 years of age and older without a developmental disability, as defined in 8.314.6 NMAC, MAD covers one prophylaxis service once in a 12 month-period.

(b) Fluoride treatment: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride treatment every six months. For a MAP eligible recipient 21 years of age and older MAD, covers one fluoride treatment once in a 12-month period.

(c) Fluoride varnish: MAD covers for a MAP eligible recipient under 21 years of age, one fluoride varnish treatment every six months.

(d) Molar sealants: MAD only covers for a MAP eligible recipient under 21 years of age, sealants for permanent molars. Each MAP eligible recipient can receive one treatment per tooth every 60 months. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the 60-month period requires a prior authorization. For a MAP eligible recipient 21 years of age and older, MAD does not cover sealant services.

(e) Space maintenance: MAD covers for a MAP eligible recipient under 21 years of age fixed unilateral and fixed bilateral space maintainers (passive appliances). For a MAP eligible recipient 21 years of age and older, MAD does not cover space maintenance services.

(5) Restorative services: MAD covers the following restorative services:

(a) amalgam restorations (including polishing) on permanent and deciduous teeth;

(b) resin restorations for anterior and posterior teeth;

(c) one prefabricated stainless steel crown per permanent or deciduous tooth;

(d) one prefabricated resin crown per permanent or deciduous tooth; and

(e) one recementation of a crown or inlay.

(6) Endodontic services: MAD covers therapeutic pulpotomy for a MAP eligible recipient under 21 years of age if

performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

(7) Periodontic services: MAD covers for a MAP eligible recipient certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(a) a collaborative practice dental hygienist may provide periodontal scaling and root planning, per quadrant after diagnosis by a MAD enrolled dentist; and

(b) a collaborative practice dental hygienist may provide periodontal maintenance procedures with prior authorization.

(8) Removable prosthodontic services: MAD covers two denture adjustments per every 12 months per MAP eligible recipient. MAD also covers repairs to complete and partial dentures.

(9) Fixed prosthodontics services: MAD covers one recementation of a fixed bridge.

(10) Oral surgery services:

(a) simple and surgical extractions: MAD coverage includes local anesthesia and routine post-operative care; erupted surgical extractions are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, or section of tooth and closure;

(b) autogenous tooth reimplantation of a permanent tooth: MAD covers for a MAP eligible recipient under 21 years of age; and

(c) the incision and the drainage of an abscess for a MAP eligible recipient.

(11) Adjunctive general services: MAD covers emergency palliative treatment of dental pain for a MAP eligible recipient. MAD also covers general anesthesia and intravenous sedation for a MAP eligible recipient. Documentation of medical necessity must be available for review by MAD or its designee. For a MAP eligible recipient under 21 years of age, MAD covers the use of nitrous oxide analgesia. For a MAP eligible recipient 21 years of age and older, MAD does not cover the use of nitrous oxide analgesia.

(12) Hospital care: MAD covers dental services normally furnished in an office setting if they are performed in an inpatient hospital setting only with a prior authorization, unless one of the following conditions exist:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient under 21 years of age has a documented medical condition for which hospitalization for even a minor procedure is medically justified; or

(c) any service which requires a prior authorization in an outpatient setting must have a prior authorization if performed in an inpatient hospital.

(13) Behavioral management: Dental behavior management as a means to assure comprehensive oral health care for persons with developmental disabilities is covered. This code allows for additional compensation to a dentist who is treating persons with developmental disabilities due to the increased time, staffing, expertise, and adaptive equipment required for treatment of a special needs MAP eligible recipient. Dentists who have completed the training and received their certification from DOH are eligible for reimbursement.

(14) Noncovered dental services: MAD does not cover dental services that are performed for aesthetic or cosmetic purposes. MAD covers orthodontic services only for a MAP eligible recipient under 21 years of age and only when specific criteria are met to assure medical necessary. MAD does not cover the following specific services:

(a) surgical tray is considered part of the surgical procedure and is not reimburse separately for tray;

(b) sterilization is considered part of the dental procedure and is not reimbursed separately for sterilization;

(c) oral preparations, including topical fluorides dispensed to a MAP eligible recipient for home use;

(d) permanent fixed bridges;

(e) procedures, appliances or restorations solely for aesthetic, or cosmetic purposes;

(f) procedures for desensitization, re-mineralization or tooth bleaching;

(g) occlusal adjustments, disking, overhang removal or equilibration;

(h) mastique or veneer procedures;

(i) treatment of TMJ disorders, bite openers and orthotic appliances;

(j) services furnished by non-certified dental assistants, such as radiographs;

(k) implants and implant-related services; or

(l) removable unilateral cast metal partial dentures.

H. Podiatry and procedures on the foot: MAD covers only medically necessary podiatric services furnished by a provider, as required by the condition of the MAP eligible recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and rules. MAD covers routine foot care if certain conditions of the foot, such as corns, warts, calluses and conditions of the nails, post a hazard to a MAP eligible recipient with a medical condition. MAD covers the treatment of warts on the soles of the feet (plantar warts). Medical justification for the performance of routine care must be documented in the MAP eligible

recipient's medical record. MAD covers the following specific podiatry services.

(1) Routine foot care: Routine foot care services that do not meet the coverage criteria of medicare part B are not covered by MAD. MAD covers services only when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination. A MAP eligible recipient with diagnoses marked by an asterisk (*) in the list below must be under the active care of a physician or physician assistant (PA). to qualify for covered routine foot care, and must have been assessed by that provider for the specified condition within six months prior to or 60-calendar days after the routine foot care service. A CNP, PA and a CNS do not satisfy the coverage condition of "active care by a PCP".

(2) Common billed diagnoses: The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:

(a) diabetes mellitus*;

(b) arteriosclerosis obliterans;

(c) buerger's disease;

(d) chronic thrombophlebitis*;

(e) neuropathies involving the feet associated with:

(i) malnutrition and vitamin deficiency*;

(ii) malnutrition (general, pellagra);

(iii) alcoholism;

(iv) malabsorption (celiac disease, tropical sprue);

(v) pernicious anemia;

(vi) carcinoma*;

(vii) diabetes mellitus*;

(viii) drugs or toxins*;

(ix) multiple sclerosis*;

(x) uremia (chronic renal disease)*;

(xi) traumatic injury;

(xii) leprosy or neurosyphilis;

(xiii) hereditary disorders;

(xiv) hereditary sensory radicular neuropathy;

(xv) fabry's disease; and

(xvi) amyloid neuropathy.

(3) Routine foot care services: MAD covers routine foot care services for a MAP eligible recipient who has a systemic condition and meets the severity in the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) class A findings: non-traumatic amputation of foot or integral skeletal portion thereof;

(b) class B findings:

(i) absent posterior tibial pulse;

(ii) absent dorsalis pedis pulse; and

(iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); or skin color (rubor or redness);

(c) class C findings:

(i) claudication;

(ii) temperature changes (e.g., cold feet);

(iii) edema;

(iv) paresthesias (abnormal spontaneous sensations in the feet); or

(v) burning.

(4) Subluxated foot structure: Non-surgical and surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when medical necessity has been documented. Treatment for bunions is limited to capsular or bony surgery. The treatment of subluxation of the foot is defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

(5) Foot warts: MAD covers the treatment of warts on the feet.

(6) Asymptomatic mycotic nails: MAD covers the treatment of asymptomatic mycotic nails in the presence of a systemic condition that meets the clinical findings and class findings as required for routine foot care.

(7) Mycotic nails: MAD covers the treatment of mycotic nails in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:

(a) marked, significant limitation;

(b) pain; or

(c) secondary infection.

(8) Orthopedic shoes and other supportive devices: MAD only covers these items when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics who is a MAP eligible recipient.

(9) Hospitalization: If the MAP eligible recipient has existing medical condition that would predispose him or her to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered.

(10)
Noncovered podiatric services: A provider is subject to the limitations and coverage restrictions that exist for other medical services. MAD does not cover the following specific services or procedures.

(a)
Routine foot care is not covered except as indicated under "covered services" for a MAP eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as:

(i)
trimming, cutting, clipping and debriding toenails;

(ii)
cutting or removal of corns, calluses, or hyperkeratosis;

(iii)
other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast MAP eligible recipient; and

(iv)
any other service performed in the absence of localized illness, injury or symptoms involving the foot.

(b)
Services directed toward the care or the correction of a flat foot condition are not covered. Flat foot is defined as a condition in which one or more arches of the foot have flattened out.

(c)
Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to a diabetic MAP eligible recipient.

(d)
Surgical or nonsurgical treatments undertaken *for the sole purpose* of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

(e)
MAD will not reimburse for services that have been denied by medicare for coverage limitations.

I. Anesthesia: MAD covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the MAP eligible recipient. All services must be provided within the limits of MAD benefit package, within the scope and practice of anesthesia as defined by state law and in accordance with applicable federal and state and local laws and rules.

(1) When a provider performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, payment for this service is considered to be part of the underlying medical or surgical service and will not be covered in addition to the procedure.

(2) An anesthesia service is not covered if the medical or surgical procedure is not a MAD covered service.

(3) Separate payment is not allowed for qualifying circumstances. Payment is considered bundled into the anesthesia allowance.

(4) Separate payment is not allowed for the anesthesia complicated by the physical status of the MAP eligible recipient.

J. Vision: MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a MAP eligible recipient. MAD pays for the correction of refractive errors required by the condition of the MAP eligible recipient. All services must be furnished within the limits of the MAD benefits package, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules.

(1) Vision exam: MAD covers routine eye exams. Coverage for an eligible adult recipient 21 years of age and older of age is limited to one routine eye exam in a 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the MAP eligible recipient's visual examination record and indicated by diagnosis on the claim. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period.

(2)
Noncovered vision services: MAD does not cover vision services that are performed for aesthetic or cosmetic purposes. MAD covers orthoptic assessments and treatments only when specific criteria are met to assure medical necessity.

K. Hearing: All audiology screening, diagnostic, preventive or corrective services require medical clearance. Audiologic and vestibular function studies are rendered by an audiologist or a PCP. Hearing aid dealers and dispensers are not reimbursed for audiological, audiometric or other hearing tests. Only licensed audiologists and PCPs are reimbursed for providing these testing services.

L. Client medical transportation: MAD covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MAP eligible recipient in or out of his or her home community. See 42 CFR 440.170. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the MAP eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the MAP eligible recipient to the medical or behavioral health examination or treatment. MAD reimburses a MAP eligible recipient or the transportation provider for medically necessary transportation subject to the following.

(1) Free alternatives: Alternative transportation services which may be provided free of charge include volunteers, relatives or transportation services provided by a nursing facility (NF) or another residential center. A MAP eligible recipient must certify in writing that they do not have access to free alternatives.

(2) Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the MAP eligible recipient's medical or behavioral health condition. If a MAP eligible recipient can use a private vehicle or public transportation, those alternatives must be used before the MAP eligible recipient can use more expensive transportation alternatives.

(3) Non-emergency transportation service:

(a) MAD covers non-emergency transportation services for a MAP eligible recipient who does not have primary transportation to a MAD covered service and who is unable to access a less costly form of public transportation.

(b) MAP eligible recipients released from incarceration at a correctional facility may be transported by a New Mexico medicaid transportation provider to a pharmacy to fill and retrieve prescribed medication. The eligible recipient must have a valid prescription that is qualified to be filled or re-filled at the time of their release from incarceration.

(4) Long distance common carriers: MAD covers long distance services furnished by a common carrier if the MAP eligible recipient must leave his or her home community to receive medical or behavioral health services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the MAP eligible recipient's local county income support division (ISD) office.

(5) Ground ambulance services: MAD covers services for a MAP eligible recipient provided by ground ambulances when:

(a) an emergency which requires ambulance service is certified by the attending provider or is documented in the provider's records as meeting emergency medical necessity as defined as:

(i) an emergency condition that is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant individual, the health of the individual or their unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part; and

(ii) medical necessity for ambulance services is established if the MAP eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the MAP eligible recipient's health.

(b) Scheduled, non-emergency ambulance services: These services are covered when ordered by the MAP eligible recipient's attending provider who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's medical or behavioral condition.

(c) Reusable items and oxygen: MAD covers non-reusable items and oxygen required during transportation. Coverage for these items is included in the base rate reimbursement for a ground ambulance;

(6) Air ambulance services: MAD covers services for a MAP eligible recipient provided by an air ambulance, including a private airplane, if an emergency exists and the medical necessity for the service is certified by their attending provider.

(a) An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the MAP eligible recipient (or with respect to a pregnant individual, the health of the individual or their unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(b) MAD covers the following services for air ambulances:

(i) non-reusable items and oxygen required during transportation;

(ii) professional attendants required during transportation; and

(iii) detention time or standby time up to one hour without provider documentation; if the detention or standby time is more than one hour, a statement from the attending provider or flight nurse justifying the additional time is required.

(7) Lodging services: MAD covers lodging services if a MAP eligible recipient is required to travel to receive medical or behavioral health services and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, in-state lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15-calendar days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the attending provider's statement of need. Authorization

forms for direct payment to a MAD approved lodging provider by MAD are available through local county ISD offices. In addition, overnight lodging could include the following situations:

(a) a MAP eligible recipient who is required to travel more than four hours each way to receive medical or behavioral health services; or

(b) a MAP eligible recipient who is required to travel less than four hours each way and is receiving daily medical or behavioral health services and is not sufficiently stable to travel or must be near a facility because of the potential need for emergency or critical care.

(8) Meal services: MAD covers meals if a MAP eligible recipient is required to leave his or her home community for eight hours or more to receive medical or behavioral health services. Authorization forms for direct payment to a meal provider by MAD are available through local county ISD offices.

(9) Coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for a MAP eligible recipient for one attendant if the medical necessity for the attendant is certified in writing by the MAP eligible recipient's attending provider or the MAP eligible recipient who is receiving medical service is under 18 years of age. MAD only covers transportation services or related expenses for a MAP eligible recipient and as certified, his or her attendant. Transportation services and related expenses will not be reimbursed by MAD for any other individual accompanying the MAP eligible recipient to a MAD covered medical or behavioral health service.

(10) Coverage for a MAP eligible waiver recipient: Transportation of a MAP eligible waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy or an outpatient behavioral health therapy.

(11) Out-of-state transportation and related expenses: All out-of-state transportation, meals and lodging must be prior approved by MAD or its designee. Out-of-state transportation is approved only if the out-of-state medical or behavioral health service is approved by MAD or its designee. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

(a) Requests for out-of-state transportation must be coordinated through MAD or its designee;

(b) Authorization for lodging and meal services by an out-of-state provider can be granted for up to 30-calendar days by MAD or its designee. Re-evaluation authorizations are completed prior to expiration and every 30-calendar days, thereafter.

(c) Border cities: A border city is a city within 100 miles of a New Mexico border (Mexico excluded). Transportation to a border city is treated as in-state provider service. A MAP eligible recipient who receives a MAD reimbursable service from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, to determine when a provider is considered an out-of-state provider or a border area provider.

(12) Client medical transportation fund: In a non-emergency situation, a MAP eligible recipient can request reimbursement from the client medical transportation (CMT) fund through his or her local county ISD office for money spent on transportation, meals and lodging by the MAP eligible recipient; for reimbursement from the CMT fund, a MAP eligible recipient must apply for reimbursement within 30-calendar days from the date of appointment or the date they are discharged from the hospital.

(a) Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the MAD approved provider visit to receive reimbursement:

(i) submit a letter on the provider's stationary which indicates that the MAP eligible recipient kept the appointment for which the CMT fund reimbursement is requested; for medical or behavioral health services, written receipts confirming the date of service must be given to the MAP eligible recipient for submission to the local county ISD office;

(ii) proper referral with original signatures and documentation stating that the MAD services are not available within the community from the MAD requesting provider, when a referral is necessary;

(iii) verification of current eligibility of the recipient for a MAD service for the month the appointment and travel is made;

(iv) certification that free alternative transportation services are not available and that the MAP eligible recipient is not enrolled in a HSD contracted managed care organization (MCO);

(v) verification of mileage; and

(vi) documentation justifying a medical attendant.

(b) Preparation of referrals for travel outside the home community: If a MAP eligible recipient must travel over 65 miles from his or her home community to receive medical care, the transportation provider must obtain a written verification from the referring provider or from the service provider containing the following information for the provider to retain with their billing records:

(i) the medical, behavioral health or diagnostic service for which the MAP eligible recipient is being referred;

(ii) the name of the out of community medical or behavioral health provider; and

(iii)
justification that the medical or behavioral health care is not available in the home community.

(c)
Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. An emergency is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical or behavioral health appointment.

(i)
The ISD CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate utilization review (UR) contractor verifies that the recipient is eligible for a MAD service and has a medical or behavioral health appointment prior to advancing money from the CMT fund and that the MAP eligible recipient is not enrolled in a HSD contracted MCO;

(ii)
written referral for out of community service must be received by the CMT fund custodian or a MAD FFS coordinated service contractor or the appropriate UR contractor no later than 30-calendar days from the date of the medical or behavioral health appointment for which the advance funds were requested. If a MAP eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated; see Section OIG-900, Restitutions.

(d)
MAP Eligible recipients enrolled in a HSD contracted MCO: A member enrolled in HSD contracted MCO on the date of service is not eligible to use the client medical transportation fund for services that are the responsibility of the MAP eligible recipient's MCO.

(13)
Noncovered transportation services: Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a non-covered MAD service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

(a)
an attendant where there is not the required certification from the MAP eligible recipient's medical or behavioral health provider;

(b)
minor aged children of the MAP eligible recipient that are simply accompanying them to medical or behavioral health services;

(c)
transportation to a non-covered MAD service;

(d)
transportation to a pharmacy provider with the exception for justice-involved MAP eligible recipients who are released from incarceration at a correctional facility within the first seven days of release; see 8.324.7 NMAC.

M. Telehealth services:

(1)
Telemedicine visits: An interactive HIPAA compliant telecommunication system must include both interactive audio and video and be delivered on a real-time basis at the originating and distant sites. If real-time audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person as a face to face encounter. Coverage for services rendered through telemedicine shall be determined in a manner consistent with medicaid coverage for health care services provided through in person consultation. For telemedicine services, when the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to IHS facilities or tribal contract facilities. Provision of telemedicine services does not require that a certified medicaid healthcare provider be physically present with the MAP eligible recipient at the originating site unless the telemedicine consultant at the distant site deems it necessary.

(a)
Telemedicine originating-site: The location of a MAP eligible recipient at the time the service is being furnished via an interactive telemedicine communications system. The origination-site can be any of the following medically warranted sites where services are furnished to a MAP eligible recipient.

(i)
The office of a physician or practitioner.

(ii)
A critical access hospital (as described in section 1861 (mm)(1) of the Act).

(iii)
A rural health clinic (as described in 1861 (mm)(2) of the Act).

(iv)
A federally qualified health center (as defined in section 1861 (aa)(4) of the Act).

(v)
A hospital (as defined in section 1861 (e) of the Act).

(vi)
A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(vii)
A skilled nursing facility (as defined in section 1819(a) of the Act).

(viii)
A community mental health center (as defined in section 1861(ff)(3)(B) of the Act).

(ix)
A renal dialysis facility (only for the purposes of the home dialysis monthly ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act).

(x)
The home of an individual (only for purposes of the home dialysis ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act).

(xi)
A mobile stroke unit (only for the

purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke provided in accordance with section 1834(m)(6) of the Act).

(xii) The home of an individual (only for the purposes of treatment of a substance use disorder or a co-occurring mental health disorder), furnished on or after July 1, 2019, to an individual with a substance use disorder diagnosis.

(xiii) The home of an individual when an interactive audio and video telecommunication system that permits real-time visit is used between the eligible provider and the MAP eligible recipient.

(xiv) A School Based Health Center (SBHC) as defined by section 2110(c)(9) of the Act.

(b) Telemedicine distant-site: The location where the telemedicine provider is physically located at the time of the telemedicine service. All services are covered to the same extent the service and the provider are covered when not provided through telemedicine. For these services, use of the telemedicine communications system fulfills the requirement for a face-to-face encounter.

(c) Telemedicine reimbursement: MAD covers both distant (where the eligible provider is located) as well as the originating sites (where the MAP eligible recipient is located, if another eligible provider accompanies the patient). If audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person and no additional reimbursement is made.

(d) Telemedicine providers: Reimbursement for professional services at the originating-site and the distant-site are made at the same rate as when the services provided are furnished without the use of a telecommunication system. In addition, reimbursement is made to the originating-site for a real-time interactive audio/video technology telemedicine system fee (where the MAP eligible recipient is located, if another eligible provider accompanies the patient) at the lesser of the provider's billed charge, or the maximum allowed by MAD for the specific service of procedure. If the originating site is the patient's home, the originating site fee should not be billed if the eligible provider does not accompany the MAP eligible recipient. The MAP eligible recipient is not reimbursed for their computer/internet.

(e) A telemedicine originating-site communication system fee is covered if the MAP eligible recipient was present at and participated in the telemedicine visit at the originating-site and the system that is used meets the definition of a telemedicine system.

(2) Telephone visits: MAD will reimburse eligible providers for limited professional services delivered by telephone without video. No additional reimbursement is made to the originating-site for an interactive telemedicine system fee.

(3) MAD will reimburse for services delivered through store-and-forward. To be eligible for payment under store-and-forward, the service must be provided through the transference of digital images, sounds, or previously recorded video from one location to another; to allow a consulting provider to obtain information, analyze it, and report back to the referring physician providing the telemedicine consultation. Store-and-forward telemedicine includes encounters that do not occur in real time (asynchronous) and are consultants that do not require face-to-face live encounter between patient and telemedicine provider.

(4) Noncovered telemedicine services: A service provided through telemedicine is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telemedicine. Telemedicine services are not covered when audio/video technology is used in furnishing a service when the MAP eligible recipient and the practitioner are in the same institutional or office setting.

N. Pregnancy termination services: MAD does not cover the performance of 'elective' pregnancy termination procedures. MAD will only pay for services to terminate a pregnancy when certain conditions are met.

(1) Prior to performing pregnancy termination services providers must complete and file in the MAP eligible recipient medical record, a consent for pregnancy termination that includes written certification of a provider that the procedure meets one of the following conditions:

(a) the procedure is necessary to save the life of the MAP eligible recipient as certified in writing by a provider;

(b) the pregnancy is a result of rape or incest, as certified by the treating provider, the appropriate reporting agency, or if not reported, the MAP eligible recipient is not physically or emotionally able to report the incident; or

(c) the procedure is necessary to terminate an ectopic pregnancy; or

(d) the procedure is necessary because the pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical, emotional or mental health of the MAP eligible recipient.

(2) Psychological services: MAD covers behavioral health services for a pregnant MAP eligible recipient.

(3) Oral medications: MAD covers oral medications approved by the FDA have been determined a benefit by MAD for pregnancy termination.

MAD will cover oral medications when administered by a provider acting within the scope of his or her practice board and licensure.

(4) Informed consent: Under New Mexico law, the provider may not require any MAP eligible recipient to accept any medical service, diagnosis, or treatment or to undergo any other health service provided under the plan if the MAP eligible recipient objects on religious grounds or in the case of a non-emancipated MAP eligible recipient, the legal parent or guardian of the non-emancipated MAP eligible recipient objects.

(a) Consent: Voluntary, informed consent by a MAP eligible recipient 18 years of age and older, or an emancipated minor MAP eligible recipient must be given to the provider prior to the procedure to terminate pregnancy, except in the following circumstances:

(i) in instances where a medical emergency exists; a medical emergency exists in situations where the attending PCP certifies that, based on the facts of the case presented, in his or her best clinical judgment, the life or the health of the MAP eligible recipient is endangered by the pregnancy so as to require an immediate pregnancy termination procedure;

(ii) in instances where the MAP eligible recipient is unconscious, incapacitated, or otherwise incapable of giving consent; in such circumstances, the consent shall be obtained as prescribed by New Mexico law;

(iii) in instances where pregnancy results from rape or incest or the continuation of the pregnancy endangers the life of the MAP eligible recipient;

(iv) consent is valid for 30-calendar days from the date of signature, unless withdrawn by the MAP eligible recipient prior to the procedure.

(b) Required acknowledgements: In signing the consent, the MAP eligible recipient must acknowledge that they have received, at least, the following information:

(i) alternatives to pregnancy termination;

(ii) medical procedure(s) to be used;

(iii) possibility of the physical, mental, or both, side effects from the performance of the procedure;

(iv) right to receive pregnancy termination behavioral health services from an independent MAD provider; and

(v) right to withdraw consent up until the time the procedure is going to be performed.

(c) Record retention: A dated and signed copy of the consent, with counseling referral information, if requested, must be given to the MAP eligible recipient. The provider must keep the original signed consent with the MAP eligible recipient's medical records.

(d) Consent for a MAP eligible recipient under 18 years of age who is not an emancipated minor, in instances not involving life endangerment, rape or incest: Informed written consent for an non-emancipated minor to terminate a pregnancy must be obtained, dated and signed by a parent, legal guardian, or another adult acting 'in loco parentis' to the minor. An exception is when the minor objects to parental involvement for personal reasons or the parent, guardian or adult acting 'in loco parentis' is not available. The treating PCP shall note the minor's objections or the unavailability of the parent or guardian in the minor's chart, and:

(i) certify in his or her best clinical judgment, the minor is mature enough and well enough informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, certify that the procedure is in the minor's best interests based on the information provided to the treating PCP by the minor; or

(ii) refer the minor to an independent MAD behavioral health provider in circumstances where the treating PCP believes behavioral health services are necessary before a clinical judgment can be rendered on the criteria established in Paragraph (1) above; the referral shall be made on the same day of the visit between the minor and the treating PCP where consent is discussed; the independent MAD behavioral health provider shall meet with the minor and confirm in writing to the treating PCP whether or not the minor is mature enough and sufficiently informed to make the decision about the procedure; in the circumstance where sufficient maturity and information is not present or apparent, that the procedure is in the minor's best interests based on the information provided to the independent MAD behavioral health provider by the minor; this provider's written report is due to the treating PCP within 72 hours of initial referral;

(iii) a minor shall not be required to obtain behavioral health services referenced in Paragraph (2) above; however, if the treating PCP is unable or unwilling to independently certify the requirements established in Paragraph (1) above, the minor must be informed by the treating PCP that written consent must be obtained by the parent, legal guardian or parent 'in loco parentis' prior to performing the procedure; or, that the minor must obtain a court order allowing the procedure without parental consent.

O. Behavioral health professional services: Behavioral health services are addressed specifically in 8.321.2 NMAC.

P. Experimental or investigational services: MAD covers medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD. MAD does not cover experimental or investigational medical, surgical or health care procedures or treatments, including the use of drugs, biological products, other products or devices, except the following:

(1) Phase I, II, III or IV: MAD may approve coverage for routine patient care costs incurred as a result of the MAP eligible recipient's participation in a phase I, II, III, or IV cancer trial that meets the following criteria. The cancer clinical trial is being conducted with the approval of at least one of the following:

(a) one of the federal national institutes of health;

(b) a federal national institutes of health cooperative group or center;

(c) the federal department of defense;

(d) the FDA in the form of an investigational new drug application;

(e) the federal department of veteran affairs; or

(f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility.

(2) Review and approval: The clinical trial has been reviewed and approved by an institutional review board that has a multiple project assurance contract approved by the office of protection from research risks of the federal national institutes of health.

(3) Experimental or investigational interventions: Any medical, surgical, or other healthcare procedure or treatment, including the use of a drug, a biological product, another product or device, is considered experimental or investigational if it meets any of the following conditions:

(a) current, authoritative medical and scientific evidence regarding the medical, surgical, or other health care procedure or treatment, including the use of a drug, a biological product, another product or device for a specific condition shows that further studies or clinical trials are necessary to determine benefits, safety, efficacy and risks, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting;

(b) the drug, biological product, other product, device, procedure or treatment (the "technology") lacks final approval from the FDA or any other governmental body having authority to regulate the technology;

(c) the medical, surgical, other health care procedure or treatment, including the use of a drug, a biological product, another product or device is the subject of ongoing phase I, II, or III clinical trials or under study to determine safety, efficacy, maximum tolerated dose or toxicity, especially as compared with standard or established methods or alternatives for diagnosis or treatment or both outside an investigational setting.

(4) Review of conditions: On request of MAD or its designee, a provider of a particular service can be required to present current, authoritative medical and scientific evidence that the proposed technology is not considered experimental or investigational.

(5) Reimbursement: MAD does not reimburse for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products or devices that are considered experimental or investigational, except as specified as follows. MAD will reimburse a provider for routine patient care services, which are those medically necessary services that would be covered if the MAP eligible recipient were receiving standard cancer treatment, rendered during the MAP eligible recipient's participation in phase I, II, III, or IV cancer clinical trials.

(6) Experimental or investigational services: MAD does not cover procedures, technologies or therapies that are considered experimental or investigational.

Q. Smoking/Tobacco cessation: MAD covers tobacco cessation services for all MAP eligible recipients.

(1) Eligible medical, dental, and behavioral health practitioner: Cessation counseling services may be provided by one of the following:

(a) by or under the supervision of a physician; or

(b) by any other MAD enrolled health care professional authorized to provide other MAD services who is also legally authorized to furnish such services under state law;

(c) generally, eligible practitioners would be medical practitioners, including independently enrolled CNPs, behavioral health and dental practitioners; physician assistants and CNPs not enrolled as independent MAD providers, and registered nurses and dental hygienists may bill for counseling services through the enrolled entity under which their other services are billed, when under the supervision of a dentist or physician;

(d) counseling service must be prescribed by a MAD enrolled licensed practitioner.

(2) Eligible pharmacy providers: For rendering tobacco cessation services, eligible pharmacists are those who have attended at least one continuing education course on tobacco cessation in accordance with the federal public health guidelines found in the United States department of health and human services; public health services' *quick reference guide for clinicians*, and *treating tobacco use and dependence*.

(3) Tobacco cessation drug items: MAD covers all prescribed tobacco cessation drug items for a MAP eligible recipient as listed in this section when ordered by a MAD enrolled prescriber and dispensed by a MAD enrolled pharmacy. MAD does not require prior authorization for reimbursement for tobacco cessation products, but the items must be prescribed by a MAD enrolled practitioner. Tobacco cessation products include, but are not limited to the following:

(a) sustained release buproprion products;

(b) varenicline tartrate tablets; and

(c) prescription and over-the-counter (OTC) nicotine replacement drug products, such as lozenges, patches, gums, sprays and inhalers.

(4) Covered services: MAD makes reimbursement for assessing all MAP eligible recipient's tobacco dependence including a written tobacco cessation treatment plan of care as part of an evaluation and management (E&M) service, and may bill using the E&M codes. MAD covers face-to-face counseling when rendered by an appropriate provider. The effectiveness of counseling is comparable to pharmacotherapy alone. Counseling plus medication provides additive benefits. Treatment may include prescribing any combination of tobacco cessation products and counseling. Providers can prescribe one or more modalities of treatment. Cessation counseling session refers face-to-face MAP eligible recipient contact of either

(a) intermediate session (greater than three minutes up to 10 minutes); or

(b) intensive session (greater than 10 minutes).

(5) Documentation for counseling services: Ordering and rendering practitioners must maintain sufficient documentation to substantiate the medical necessity of the service and the services rendered, which may consist of documentation of tobacco use. The rendering practitioner must maintain documentation that face-to-face counseling was prescribed by a practitioner, even if the case is a referral to self, consistent with other NMAC rules and other materials.

(6) Limitations on counseling sessions: The services do not have any limits on the length of treatment or quit attempts per year. The program also allows participants to try multiple treatments and does not impose any requirement to enroll into counseling. During the 12-month period, the practitioner and the MAP eligible recipient have flexibility to choose between intermediate or intensive counseling modalities of treatment for each session.

R. Screening, brief intervention and referral to treatment (SBIRT) service: 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 physical health 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 behavioral health treatment, the certified SBIRT staff, with the eligible recipient's approval, assists in securing behavioral health services. Only a physical health office, clinic, or facility who has been certified by a HSD approved SBIRT trainer and uses the approved healthy lifestyle questionnaire (HLQ) can complete the screen. The physical office, clinic or facility must be the billing provider, not the individual practitioner. All practitioners must be SBIRT certified and are employees or contractors of a SBIRT physical health office, clinic or facility. See the SBIRT policy and billing manual for detailed description of the service and billing requirements.

S. Other services: Other covered and noncovered services including hospitalization and other residential facilities, devices for hearing and vision correction, behavioral health services, home and community based services, EPSDT services, case management and other adjunct and specialty services are described in other NMAC rules.

[8.310.2.12 NMAC - Rp, 8.310.2.12 NMAC, 1/1/2014; A, 8/10/2021; A, 4/5/2022; A/E, 1/1/2025]

TRANSPORTATION, DEPARTMENT OF

This is an emergency amendment to 18.3.4 NMAC, Section 12, effective 12/23/2024.

18.3.4.12 REQUIREMENTS APPLICABLE ONLY TO NON-CDL DRIVERS:

A. Operators' licenses: is rule adopts by reference the licensing provisions of the New Mexico motor vehicle code, Sections 66-5-1 through 66-5-48, NMSA 1978.

B. Qualifications, investigations, inquiries, reporting, records, driving, equipment, inspection repair and maintenance by and for all passenger vehicles and drivers:

(1) Before allowing a transportation service driver to provide carriage:

(a) the prospective driver shall submit an application to the transportation service that includes the individual's address, age, driver's license number and state, and driving history;

(b) the transportation service shall obtain a local and national criminal background check for the prospective driver that shall include:

(i) multistate or multi-jurisdiction criminal records locator or other similar commercial nationwide database with validation and primary source search; and

(ii) a national sex offender registry; and

(iii) the transportation service shall obtain and review a driving history research report for the prospective driver.

(2) A transportation service shall not permit a person to act as a transportation service driver who:

(a) has had more than three moving violations in the preceding three-

year period or one violation in the preceding three-year period involving any attempt to evade law enforcement, reckless driving or driving on a suspended or revoked license;

(b) has been convicted within the past seven years of:

(i) a felony;

(ii) misdemeanor driving under the influence, reckless driving, leaving the scene of an accident or any other driving-related offense or any misdemeanor violent offense or sexual offense; or

(c) more than three misdemeanors of any kind;

(d) is identified by a national sex offender registry;

(e) does not possess a valid license; or

(f) is not at least 21 years old, except as provided in Subparagraph (g) of Paragraph (2) of Subsection B of 18.3.4.12 NMAC; or

(g) with respect to drivers of full-service ambulance services, is not at least 18 years old.

(3) A transportation service shall not use a small passenger vehicle that:

(a) is not in compliance with all federal, state and local laws concerning the operation and maintenance of the motor vehicle;

(b) has fewer than four doors; or

(c) is designed to carry more than eight passengers, including the driver.

(4) A transportation service shall inspect or cause to be inspected every motor vehicle used by a driver to provide transportation services before allowing the driver to use the motor vehicle to provide transportation services and not less than once each year thereafter. The type of inspection required shall follow the commission rules for annual inspections for transportation network company service driver vehicles promulgated as 18.l7.1.8 NMAC.

(5) Provided that passenger services may voluntarily adopt and implement other more stringent policies and procedures for small passenger vehicles and drivers of small passenger vehicles, including full or modified forms of federal safety policies and procedures.

C. Qualifications of drivers: This rule adopts by reference only the following specific sections of 49 CFR Part 391:

(1) general qualifications of drivers: Section 391.11(b)(8);

(2) application for employment: Section 391.21;

(3) investigations and inquiries: Section 391.23, except that Section 391.23(d)(2) the term "as specified in section 390.15(b)(1) of this chapter" is substitute for this rule by the term, "in the uniform crash report form prescribed by the state of New Mexico";

(4) annual inquiry and review of driving record: Section 391.25, except that:

(a) Subsections 391.25(a) and (b) are amended to delete: "Except as provided in subpart G of this part;"

(b) Section 391.25 shall not apply to volunteer drivers;

(5) record of violations: Section 391.27, except that section 391.27(a) is amended to delete: "Except as provided in subpart G of this part;"

(6) road test: Section 391.31, except that section 391.31(a) is amended to delete: "Except as provided in subpart G;"

(7) equivalent of road test: Section 391.33; except that an ambulance service may also accept from a person who seeks to drive an ambulance a copy of a certificate of completion from an emergency vehicle operator's course approved by the emergency medical services (EMS) bureau of the department of health (DOH);

(8) physical qualifications for drivers: Section 391.41, except that drivers for ambulance are exempt from Section 391.41(a);

(9) medical examinations; certificate of physical examination: Section 391.43, except that for volunteer drivers of ambulance services only, the medical examiner (as defined in 49 CFR Section 390.5) shall perform a medical examination sufficient to enable the medical examiner to certify, in accordance with Subsection C of 18.19.5.33 NMAC, whether or not the driver has a condition that may interfere with the safe operation of an ambulance;

(10) persons who must be medically examined and certified: Section 391.45, except that this section shall not apply to volunteer drivers;

(11) general requirements for driver qualification files: Section 391.51, except that Subsections 391.51(b)(8) and (d)(5) are not adopted;

(12) driver investigation history file: Section 391.53, except that this section shall not apply to commuter services.

D. Driving of commercial motor vehicles: This rule adopts by reference the following sections of 49 CFR Part 392:

(1) ill or fatigued operator: Section 392.3;

(2) drugs and other substances: Section 392.4;

(3) alcohol prohibition: Section 392.5;

(4) emergency equipment, inspection and use: Section 392.8, except that this section is amended to substitute "Section 66-3-849 NMSA 1978", certain vehicles to carry flares or other warning devices, for the federal reference to "Section 393.95";

(5) inspection of cargo, cargo securement devices and systems: Section 392.9**,** except that this section shall only apply to a motor vehicle with a gross vehicle

weight rating of 10,000 pounds or more;

(6) hazardous conditions; extreme caution: Section 392.14, except that this section shall not apply to ambulance services;

(7) use of seat belts: Section 392.16;

(8) obscured lamps or reflectors: Section 392.33;

(9) ignition of fuel; prevention: Section 392.50;

(10) safe operation, buses: Section 392.62;

(11) towing or pushing loaded buses: Section 392.63;

(12) riding within closed commercial motor vehicles without proper exits: Section 392;

(13) carbon monoxide; use of commercial motor vehicle when detected: Section 392.66;

(14) radar detectors; use and/or possession: Section 392.71.

E. Equipment for vehicles, seatbelts and child restraints: This rule adopts by reference Sections 66-3-801 through 66-3-901 NMSA 1978. In addition, passenger vehicles capable of transporting 15 or fewer persons including the driver shall provide a separate seat belt assembly for each passenger and shall ensure child restraint systems comply with all federal and state requirements.

F. Inspection, repair and maintenance for vehicles: This rule adopts by reference the following sections of 49 CFR Part 396:

(1) inspection, repair and maintenance: Section 396.3, but this section shall not apply to commuter services;

(2) lubrications: Section 396.5;

(3) driver vehicle inspection reports: Section 396.1;

(4) driver inspection: Section 396.13;

(5) periodic inspection: Section 396.17;

(6) inspector qualifications: Section 396.19;

(7) periodic inspection recordkeeping requirements: Section 396.21;

(8) equivalent to periodic inspection: Section 396.23(a);

(9) qualifications of brake inspectors: Section 396.25.

[18.3.4.12 NMAC - Rp, 18.3.4.12 NMAC, 7/1/2024; A/E, 12/23/2024]

WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.3 NMAC, Sections 8 and 11, effective 1/1/2025.

11.4.3.8 PAYMENT OF CLAIMS:

A. If an accidental injury or occupational disease occurs to a worker during the course of employment and results in lost time to the worker of more than seven cumulative days, the employer shall file an E1.2 report with the WCA, and shall concurrently provide a copy to the worker.

B. The employer shall pay the worker the first and remaining [~~installment~~] installments of compensation benefits in accordance with Section 52-1-30 NMSA 1978. [~~on a compensable claim no later than 14 days of the date of filing of the E1.2 report with the WCA.~~]

C. If a claim is denied, the employer shall, upon the request of the worker, provide a written statement of the basis for the denial within 30 days of receiving a request.

D. Compromise payments by the employer shall not be construed as an admission of liability by any person or party.

[5/2/87, 5/26/87, 5/29/91, 6/1/96; 11.4.3.8 NMAC - Rn, 11 NMAC 4.3.8, 11/30/04; A, 6/16/16; A, 1/1/2025]

11.4.3.11 MILEAGE BENEFITS:

A. Employer shall pay worker's mileage, transportation, meal and commercial lodging expenses for travel to HCPs pursuant to this rule. Payment shall be made only to the injured worker and within 30 days of the employer's receipt of an original itemized receipt that complies with the requirements of this rule:

(1) for travel to HCPs of 15 miles or more, one way, from the worker's residence or place of employment, depending upon the point of origin of travel, mileage shall be reimbursed at the mileage reimbursement rate set by the New Mexico department of finance and administration regulations in effect on the date of travel;

(2) actual reimbursement for the cost of a ticket on a common carrier, if applicable;

(3) actual reimbursement up to $ [~~15.00~~] 25 for any one meal with up to three meals total and $ [~~30~~] 75 total reimbursed for a 24 hour period; and,

(4) actual reimbursement up $ [~~85.00~~] 150 for the cost of overnight commercial lodging in the event of required travel of at least 150 miles one way from worker's residence or place of employment, depending upon the point of origin of travel.

B. Unless a judge otherwise orders, [~~The~~] the employer in its sole discretion may make payments under this section in advance. If worker accepts an advance payment and fails to appear for the scheduled HCP or IME appointment for which an advance has been issued, the employer/insurer may deduct the amount of the advance from the present indemnity benefits.

[5/26/87...6/1/96; 11.4.3.11 NMAC - A/E, 11/15/04; 11.4.3.11 NMAC - Rn, 11 NMAC 4.3.11, 11/30/04; A/E, 2/19/10; A, 12/31/12; A, 6/30/16; A, 1/1/2025]

WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.4 NMAC, Sections 13, 16, and 18, effective 1/1/2025.

11.4.4.13 ADJUDICATION PROCESS:

A. Assignment of judge:

(1) Upon receipt of a timely rejection of a recommended resolution, an application to judge or petition for lump sum payment, the clerk shall assign a judge to the case and shall serve notice on all parties. Pro se parties shall be served by certified mail unless registered with the WCA electronic filing system. This notice shall be considered the initial notice of judge assignment.

(2) Each party shall have the right to disqualify a judge by filing a notice of disqualification of judge no later than 10 days from the date of filing of the notice of assignment of judge. The clerk shall assign a new judge to the case and notify all registered parties. A party who has not exercised the right of disqualification may do so no later than 10 days from the filing of the notice of reassignment of judge.

(3) No action may be taken by any judge on a case until the expiration of the time for all parties to exercise the peremptory right to disqualify a judge. To expedite the adjudication process, the parties may file a joint waiver of the right to disqualify a judge. Such waiver shall forever bar the parties' right to disqualify a judge in that case.

(4) Disputes related to the assignment, re-assignment, or disqualification of a judge shall be raised by written application to the director, which shall be filed with the clerk.

(5) The director may designate an on-call judge for the limited purpose of reviewing and approving lump sum payment petitions on a voluntary walk-in basis. The director shall provide notice to the public about the schedule for any on-call judge availability. Such designation shall not be considered a judge assignment or reassignment under this section if further adjudication action is needed.

B. Application to judge:

(1) Unless otherwise provided, all claims under the act shall be initiated by filing a complaint form, and the clerk shall schedule the claim for mediation. A party may file an application to judge, and the clerk shall assign the case to a judge to adjudicate the following limited forms of relief only:

(a) physical examination pursuant to Section 52-1-51 NMSA 1978;

(b) independent medical examination pursuant to Section 52-1-51 NMSA 1978;

(c) determination of bad faith, unfair claims processing, fraud or retaliation;

(d) supplemental compensation order;

(e) award of attorney fees;

(f) stipulated reimbursement agreement pursuant to Section 52-5-17 NMSA 1978;

(g) consolidation of payments into quarterly payments (not a lump sum under Section 52-5-12 NMSA 1978);

(h) approval of limited discovery where no complaint is pending before the agency, including but not limited to approval of a communication to a treating health care provider when the parties cannot otherwise agree on the form or content; or

(i) request for release of medical records.

(2) If any claim not enumerated above is raised on an application to judge, the application shall be deemed a complaint and the clerk shall refer it for mediation.

(3) For an application seeking relief under Subparagraphs (a) (b) (c) (d) (h) or (i) of Paragraph 1 of Subsection A of 11.4.4.13 NMAC above, an application to judge may not be filed if a complaint has been filed in the same case and the time period for acceptance or rejection of the recommended resolution has not yet expired. Any other claim for relief arising during that time period shall be raised in the mediation process.

(4) Following the rejection of a recommended resolution and during the pendency of a complaint, those claims for forms of relief set forth above shall be sought through motion rather than an application.

(5) Responses to an application to a judge, if any, shall be filed within 15 days of service. A response to application to judge may not raise new claims or issues.

(6) All applications to a judge shall be accompanied by a summons, if one has not previously been issued in the case, and a request for setting. Hearings as necessary may be scheduled by the assigned judge.

C. Petition for lump sum payment:

(1) Parties may request approval of a lump sum payment by filing the WCA mandatory petition form, which shall be signed and verified by the worker or the worker's dependents.

(2) Petitions under Subsection D of Section 52-5-12 NMSA 1978 shall also be signed by the employer or its representative or, where applicable, the UEF.

(3) Parties to lump sum payment petitions filed pursuant to Subsection D of Section 52-5-12 NMSA 1978 shall attend a lump sum payment approval hearing for a determination that the agreement is voluntary, that the worker understands the terms, conditions and consequences of the settlement agreement or any release, and that the settlement is fair, equitable and provides substantial justice to the parties. For all other joint lump sum payment petitions, a hearing may be held at the discretion of a judge pursuant to Sections 52-5-12 and 52-5-13 NMSA 1978.

(4) Any lump sum payment petition filed pursuant

to this rule shall comply with Section 52-1-54 NMSA 1978 and counsel for the parties may concurrently seek approval or award of attorney fees, if appropriate, to be heard in the context of the lump sum payment hearing.

(5) Written responses to the petition, if any, shall be filed within 10 days of service of a petition.

(6) All petitions shall be accompanied by a request for setting, and a summons, if one has not previously been issued in the case. Such hearings will be promptly scheduled by the assigned judge.

D. The adjudication process for complaints shall commence upon the clerk's receipt of a timely rejection of a recommended resolution. An answer to complaint shall be filed within 20 days of the filing of the initial notice of assignment of judge unless already filed in lieu of the informal response. The answer shall admit or deny each claim asserted in the complaint. Any affirmative defenses to the complaint shall be stated in the answer.

E. Amended complaints may be filed during the adjudication process only by leave of the assigned judge or by written consent of the adverse party. Leave shall be freely given when justice so requires. Amended complaints filed during the adjudication process shall not be referred back to the mediation process nor shall a new recommended resolution be issued.

F. The judge may hold pre-trial conferences as necessary, establish appropriate deadlines, mandate evidentiary disclosures between the parties, approve formal discovery, and otherwise control all other aspects of the adjudication process in order to enable the prompt adjudication of the case.

G. Discovery: Authorized interrogatories, requests for production or inspection, requests for admissions, depositions, and subpoenas shall be governed by the rules of civil procedure of the district courts of New Mexico.

H. Depositions: Upon the filing of a complaint and by written stipulation of the parties, good cause is presumed and depositions may be taken of the worker, employer representative, authorized HCP, and any provider of an independent medical examination.

(1) Reasonable notice shall be deemed to be not less than five days prior to the date set for the deposition.

(2) The original deposition transcript shall be kept by the party who noticed the deposition.

(3) The parties shall make a good faith effort to obtain a completed and signed form letter to HCP prior to setting the deposition of the HCP.

(4) Deposition testimony of authorized HCPs shall be admissible in lieu of live testimony.

(5) Depositions of other witnesses identified by the parties may be admissible, if noticed for use at trial, provided that nothing prohibits either party from issuing a subpoena to order the deposed witness to testify at trial.

(6) A party intending to use a deposition shall notify the other party of the intended use at least 10 days prior to trial. Any objection to the use of the deposition shall be determined at the adjudication hearing.

(7) The party that notices a deposition may request the return of the original transcript after final disposition of the case. The clerk may return a transcript or any exhibits tendered to the submitting party or its attorney. If no request for the deposition or exhibits is received, the deposition or exhibits will be destroyed. Notice of intent to destroy exhibits is published in the New Mexico bar bulletin.

I. Subpoenas: The clerk may issue a subpoena, signed but otherwise blank, to a party requesting it, who shall complete it before service. An attorney authorized to practice law in New Mexico who represents a party before the WCA may also issue and sign a subpoena as an officer of the court on behalf of the WCA. Subpoenas are not considered discovery and do not require good cause or approval from a judge.

J. Appointment of interpreter:

(1) It is the responsibility of the parties to determine if interpretive services are necessary.

(2) An interpreter may be appointed by the judge, director, or mediator. The interpreter shall be court-certified, except that a non-certified interpreter may serve at mediation conferences.

(3) The employer shall be responsible for the cost and arrangement of a qualified interpreter for the hearing or mediation conference. This responsibility may fall to the uninsured employers' fund when named as a party.

(4) The judge shall have discretion to require written discovery translated into the language of the responding party to ensure fairness and substantial justice.

K. Motions: All motions, except those made in open court, shall be written and comply with the New Mexico district court rules of civil procedure.

L. Settlement/pre-trial conferences: The judge shall have discretion to schedule settlement conferences. A settlement conference facilitated by the assigned judge shall require the consent of all parties either on the record or in writing.

M. Orders: Proposed orders or other documents requiring a judge's signature shall not be filed with the clerk but shall be submitted directly to the judge.

N. Admissibility of evidence:

(1) Live medical testimony shall not be permitted, except by an order of the judge.

(2) A judge may admit evidence, including hearsay evidence, provided that the evidence is relevant, has sufficient indicia of reliability and authenticity,

and will assist the judge in determining a fact or issue in dispute, including, but not limited to:

(a) personnel records, payroll records, or other employment files for worker;

(b) pre-injury medical records of treatment received for a period of 10 years prior to the date of injury through the time of hearing on the merits;

(c) form letters approved by the WCA;

(d) records of authorized health care providers and their referrals, including functional capacity evaluations;

(e) reports of independent medical examinations ("IMEs") performed pursuant to the act or as otherwise agreed by the parties;

(f) toxicology or drug and alcohol test reports;

(g) records of the office of medical examiner, including autopsy and toxicology reports; or

(h) records of the New Mexico board of pharmacy prescription monitoring program.

(3) On motion of a party, or by stipulation of the parties, a judge may treat admitted medical records and reports of authorized health care providers and independent medical examination as testimony for any relevant purpose other than to establish causation connection pursuant to Section 52-1-28 NMSA 1978.

O. Continuance of hearing: A judge may continue an adjudication hearing for good cause shown. All discovery, disclosure, and exchange deadlines shall be extended by a continuance unless otherwise ordered.

P. Trials and other hearings:

(1) Parties shall appear personally at the adjudication hearing, without the necessity of a subpoena. Parties shall appear personally or through their legal representatives at all other hearings properly noticed, unless excused by a judge.

(2) Failure to appear at a hearing after proper notice and without good cause may result in the imposition of sanctions.

(3) The employer shall make all necessary arrangements and pay all costs incurred for telephonic conference calls. The director or judge may appear telephonically for the conference call.

(4) All hearings shall be recorded by audio tape recording or by any other method approved by the director.

(5) Prior to commencement of the adjudication hearing, the parties shall confer with the court monitor to ensure that all exhibits are properly marked. Any exhibit to be jointly tendered shall be marked and offered as a joint exhibit. All other exhibits shall be marked by party and exhibit number or letter. Depositions shall be marked as exhibits.

(6) Under exceptional circumstances and in the interest of justice, a judge has discretion to direct or allow supplementation of evidence within 10 days of the close of the adjudication hearing.

Q. Consolidated cases:

(1) A judge may order the consolidation of cases when the issues or facts in dispute in the cases are common or when consolidation will expedite resolution of the issues or facts in dispute.

(2) A party may request an order for consolidation of cases by filing a motion requesting consolidation in each case sought to be consolidated and serving each party and their counsel, if any, for each case sought to be consolidated.

(3) Motions to consolidate cases will be adjudicated by the final judge assigned to the case with the lowest case number.

(4) A judge's order of consolidation shall be filed in each consolidated case.

(5) After consolidation, all pleadings shall only be filed in the case with the lowest case number and the case number of each consolidated case shall appear in the caption of all pleadings. The caption of the lowest case number shall appear on all pleadings.

(6) All parties of record and their counsel shall have access to view the filed pleadings for each case.

(7) In the event of an appeal, the notice of appeal shall include the case number for each consolidated case and shall be filed in the case with the lowest case number. The record proper on appeal shall include all pleadings in each of the consolidated cases.

R. Release of medical records:

(1) A judge shall decide medical record disputes. If no judge has been assigned, the clerk shall appoint a judge upon a party filing an application to judge for release of medical records.

(2) An application to judge for the release of medical records shall be allowed notwithstanding the provisions of any other rule, and shall be disposed of separate and apart from all rule provisions and procedures pertaining to resolution of other disputes arising from a claim for benefits.

(3) The judge will determine whether the protected health information in controversy is material to the resolution of any matter presently at issue or likely to be at issue in the administration of the claim and shall order the release of protected health information upon agreement of the parties or a finding of materiality by a preponderance of evidence.

(4) A bench order or formal order of release of medical records shall have the force of law with respect to the parties and to the HCP or medical facility.

(5) If an HCP or medical facility fails to provide records after a judge has ordered the release of records pursuant to this rule, then the party to receive

the records may notify the HCP or medical facility through My E-File of the obligation to produce the records and an endorsed copy of the order. If the records are not produced within five days of service of the notice, the payer's obligation to timely pay shall be tolled until the actual production of the records.

(6) If any judge involved in the adjudication of the case finds that the withholding of records of health information after an order to produce has obstructed the efficient administration or adjudication of a case, then the judge may schedule a hearing to determine if the withholding of records was unreasonable. If the judge finds after notice and an opportunity to be heard that the withholding of records by the HCP or medical facility is unreasonable, the director may find the HCP or medical facility in violation of this rule and assess a penalty pursuant to Section 52-1-61 NMSA 1978 (1990).

[11.4.4.13 NMAC - Rp, 11.4.4.13 NMAC, 1/1/2023; A, 1/1/2025]

11.4.4.16 SANCTIONS:

A. The judge may sanction any party, attorney, or personal representative for conduct that interferes with the orderly administration of the court or a hearing, including, but not limited to:

(1) rejecting a recommended resolution without reasonable basis, or without reasonable expectation of doing better at formal hearing;

(2) failing to obey a lawful order of the court;

(3) failing to appear for a hearing or deposition; [~~or~~]

(4) advancing a meritless position in order to harass or vex the opposing party; or

(5) unreasonable conduct during a deposition.

B. The judge will conduct a separate hearing on the imposition of sanctions according to the procedures in this part.

C. As a sanction, the judge may do any or all of the following:

(1) assess reasonable attorney's fees against a party pursuant to Section 52-1-54 NMSA 1978;

(2) reduce the fees of an attorney for a party;

(3) assess prejudgment interest from the date of the recommended resolution in the claim;

(4) strike a claim or defense;

(5) limit the evidence which may be introduced;

(6) dismiss an action;

(7) order the suspension or forfeiture of compensation benefits;

(8) assess expenses and costs against a party; or

(9) impose a civil penalty pursuant to Sections 52-1-28.1, 52-1-28.2, 52-3-45.1 or 52-3-45.2 NMSA 1978.

D. For patterns of misconduct beyond a single case, the judge may refer the matter to the WCA enforcement bureau for further investigation, administrative prosecution and imposition of penalties.

[11.4.4.16 NMAC - Rp, 11.4.4.16 NMAC, 1/1/2023; A, 1/1/2025]

11.4.4.18 COURT SECURITY:

A. In any case where a party believes that a potentially violent or dangerous situation might arise during a court hearing or appearance, that party, through counsel or pro se, should notify the assigned judge or clerk of the court sufficiently in advance so that appropriate security measures can be taken by the assigned judge or director in their discretion.

B. All persons entering with packages, briefcases, purses, bags and containers brought into any offices of the workers' compensation administration may be subject to search by security personnel.

C. As all workers' compensation administration buildings include courtrooms, in order to preserve and promote order during hearings, no deadly weapons of any type will be allowed. A "deadly weapon" includes any deadly weapon as defined by Section 30-1-12 NMSA 1978. Any person found entering a workers' compensation administration building with a deadly weapon may be turned away until they have secured the weapon off premises. The foregoing shall not apply to law enforcement officers and authorized security personnel.

[11.4.4.18 NMAC – N, 1/1/2025]

WORKERS' COMPENSATION ADMINISTRATION

This is an amendment to 11.4.11 NMAC, Section 8, effective 1/1/2025.

11.4.11.8 PROOF OF COVERAGE:

A. Filing requirements:

(1) Every insurer shall file proof of coverage with the workers' compensation administration within 30 days of the effective date of any workers' compensation policy or within 30 days of the date of extension, renewal, reinstatement or amendment to such policy.

(2) Every insurer shall, in the event of a policy cancellation, file a notice of cancellation with the workers' compensation administration within 10 days of such cancellation.

(3) Vendor certification

(a) In order to be certified as a vendor for submission of POC data with the workers' compensation administration, an entity must receive certification from the workers' compensation administration.

(b) In order to maintain certified vendor status, the vendor must maintain certification with the workers' compensation administration, which includes continuous compliance

with the workers' compensation administration POC business plan.

B. POC submission procedures and requirements

(1) POC data must be submitted in the IAIABC POC flat file format.

(2) A vendor must provide optional ways for insurers to submit POC data to the vendor such as hard copy, mag tape, web page form or IAIABC flat file.

(3) Once certified, vendors must notify the workers' compensation administration of any changes they make in hardware or software and complete re-certification with the workers' compensation administration prior to using such changed or new hardware or software to submit POC data. Vendors must also comply with IAIABC requirements pertaining to hardware and software changes.

(4) A current information form and sender/vendor information form must be on file with the workers' compensation administration before electronic filings will be accepted.

(5) All POC data is the property of the New Mexico workers' compensation administration and such data cannot be used for any purpose other than that designated by the workers' compensation administration.

(6) Failure to file POC data in accordance with the act and these rules will subject the insurer to penalties and fines permitted by the act and the rules.

(7) After notice and opportunity to be heard, the director may decertify a vendor for good cause shown.

C. Exempt entities:

(1) The legislatively mandated pools governed by 11.4.10 NMAC are required to provide membership information to the workers' compensation administration through the self-insurance bureau and may exempt themselves from the electronic filing requirements at their option.

(2) Self-insurance groups, authorized to provide workers' compensation insurance to their members based upon a valid and active certificate of self-insurance issued by the director of the workers' compensation administration and whose membership roster does not exceed 75 members are required to provide membership information to the workers' compensation administration through the self-insurance bureau and may exempt themselves from the electronic filing requirements at their option.

(3) Individual self-insurers in possession of a valid and active certificate of self-insurance issued by the director of the workers' compensation administration and those subsidiaries listed on such certificate are exempt from the filing requirements.

D. Affirmative election forms: Affirmative election forms for executive employees shall be deemed filed with the director pursuant to Section 52-1-7 NMSA 1978 by filing the form with the insurance carrier that is issuing or will be issuing the workers' compensation insurance policy to the employer. Election forms for executive employees need not be submitted to the WCA.

E. Proof of Coverage forms: Any proof of coverage or certificate demonstrating evidence of workers' compensation coverage required by the Workers Compensation Act, the Occupational Disease Disablement Law, or these rules including 11.4.11 NMAC, will be deemed filed in the office of the director when transmitted electronically to an electronic data interchange vendor approved by the workers' compensation administration.

[~~E~~] **F.** Referral to enforcement bureau: If proof of coverage is not provided within the deadlines given by the WCA to obtain coverage, the potential violation may be referred for investigation and prosecution in accordance with 11.4.5 NMAC.

[11.4.11.8 NMAC - Rp, 11 NMAC 4.11.8, 9/30/16; A, 1/1/2025]

End of Adopted Rules

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Issue 5	February 27	March 11
Issue 6	March 13	March 25
Issue 7	March 27	April 8
Issue 8	April 10	April 22
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Issue 13	July 26	July 15
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Issue 16	August 14	August 26
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Issue 19	September 25	October 7
Issue 20	October 9	October 21
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