

NMAC

Transmittal Form



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Volume: Issue: Publication date: Number of pages: (ALD Use Only) Sequence No.

Issuing agency name and address: Agency DFA code:

Contact person's name: Phone number: E-mail address:

Type of rule action: New Amendment Repeal Emergency Renummer (ALD Use) Recent filing date:

Title number: Title name:

Chapter number: Chapter name:

Part number: Part name:

Amendment description (If filing an amendment):

Amendment's NMAC citation (If filing an amendment):

Are there any materials incorporated by reference? Yes No Please list attachments or Internet sites if applicable.

If materials are attached, has copyright permission been received? Yes No Public domain

Specific statutory or other authority authorizing rulemaking:

Notice date(s): Hearing date(s): Rule adoption date: Rule effective date:

Concise Explanatory Statement For Rulemaking Adoption:

Findings required for rulemaking adoption:

Findings MUST include:

- Reasons for adopting rule, including any findings otherwise required by law of the agency, and a summary of any independent analysis done by the agency;
- Reasons for any change between the published proposed rule and the final rule; and
- Reasons for not accepting substantive arguments made through public comment.

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See Statement of Reasons for Adoption, attached.

Issuing authority (If delegated, authority letter must be on file with ALD):

Name:

Christopher D Woodward

Check if authority has been delegated

Title:

Assistant General Counsel

Signature: (BLACK ink only OR Digital Signature)

Christopher
Woodward

Digitally signed by
Christopher Woodward
Date: 2025.08.28 11:53:59
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Date signed:

8/28/25

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**STATE OF NEW MEXICO
BEFORE THE SECRETARY OF HEALTH**

**IN THE MATTER OF PROPOSED
REPEAL AND REPLACEMENT OF
7.27.2, 7.27.4, 7.27.5, 7.27.6, AND
7.27.11 NMAC**

**STATEMENT OF REASONS
FOR ADOPTION OF PROPOSED
REPEAL AND REPLACEMENT OF 7.27.2,
7.27.4, 7.27.5, 7.27.6, AND 7.27.11 NMAC**

The Cabinet Secretary for the New Mexico Department of Health, Gina DeBlassie (“Secretary”), adopts the proposed repeal and replacement of parts 7.27.2, 7.27.4, 7.27.5, 7.27.6, and 7.27.11 NMAC, for the reasons stated below. This decision is based on the rulemaking record in this matter, which includes Exhibits 1 through 24, the recording of the hearing, and the Report and Recommendation of the Hearing Officer, Jared Najjar, dated July 14, 2025.

In support of this action, the Secretary finds the following:

1. The Department of Health (“Department”) is authorized to promulgate regulations as may be necessary to carry out the duties of the Department and its divisions. NMSA 1978, Section 9-7-6(E).
2. Pursuant to the Emergency Medical Services Act (EMS Act) at NMSA 1978, § 24-10B-5, the Department is responsible for adopting licensing requirements for all persons who provide emergency medical services within the state of New Mexico, irrespective of whether the services are remunerated.
3. Pursuant to the EMS Act at NMSA 1978, § 24-10B-4, the Department is also responsible for: adoption of rules for emergency medical services medical direction upon the recommendation of the medical direction committee; approval of continuing

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education programs for emergency medical services personnel; adoption of rules pertaining to the training and licensure of emergency medical dispatchers and their instructors; adoption of rules, based upon the recommendations of the air transport advisory committee, for the certification of air ambulance services; and adoption of rules pertaining to authorization of providers to honor advance directives, such as emergency medical services do not resuscitate forms, to withhold or terminate care in certain pre-hospital or interfacility circumstances.

4. By letter dated April 14, 2025, the Secretary designated Mr. Najjar to serve as hearing officer for the purpose of conducting the hearing and submitting a recommendation regarding the proposed rule. Exhibit 22.

5. The purpose of the proposed repeal and replacement of rules 7.27.2, 7.27.5, 7.27.6, and 7.27.11 NMAC is to implement the EMS Act, NMSA 1978, § 24-10B-1 *et seq.*, by adopting rules concerning licensing of emergency medical services personnel (7.27.2 NMAC) and their scopes of practice (7.27.11 NMAC); rules concerning the certification of air ambulance services (7.27.5 NMAC); and rules concerning EMS advance directives (7.27.6 NMAC).

6. The purpose of the proposed repeal and replacement of rule 7.27.4 NMAC is to implement the purpose of the EMS Fund Act, NMSA 24-10A-1 *et seq.*, by adopting rules regulating programs under that statute.

7. Notice of the June 6, 2025 hearing concerning the proposed rule replacements was provided to the public in accordance with the Department of Health Act at NMSA 1978, Section 9-7-6(E), and the State Rules Act at NMSA 1978, § 14-4-5.2, which included publication in the Albuquerque Journal newspaper on May 6, 2025, and

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publication in the New Mexico Register on May 6, 2025. *See* Exhibit 20 (Affidavit of Publication in the Albuquerque Journal); Exhibit 21 (Affidavit of Publication in the NM Register).

8. The proposed rule was posted on the New Mexico Sunshine Portal website at http://statenm.secure.force.com/public/SSP_RuleHearingSearchPublic in accordance with NMSA 1978, § 14-4-5.4(A). *See* Exhibit 23 (Affidavit of Notice to the Public).

9. The proposed rule was also posted on the Department of Health website at <http://www.nmhealth.org/about/asd/cmo/rules/>, and an Internet link to that website was included within the published notice of rulemaking in accordance with NMSA 1978, § 14-4-5.2(C). *See* Exhibit 23 (Affidavit of Notice to the Public).

10. A public rule hearing was held via the Internet-based video conference platform Microsoft Teams on June 6, 2025 in accordance with NMSA 1978, Section 9-7-6(E).

11. Members of the public were afforded the opportunity to submit data, views, and arguments on the proposed rule orally and in writing, in accordance with NMSA 1978, Section 14-4-5.3, and those comments were received by the Hearing Officer until the close of the rule hearing.

12. Oral comments were received from the public during the hearing, and written comments from the public were entered into the record of the hearing as Exhibit 24.

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13. The following substantive modifications were made to the proposed rule text after the rule hearing, based on public comments:

Rule (NMAC)	Location	Edit/Adjustment	Justification
7.27.2; Licensing of EMS Personnel; 7.27.11; Supplemental Provisions (Scope)	Throughout	Deleted all references to an EMS-RN level of licensure	Public comments requested that the proposed creation of an EMS-RN license designation be struck from the rules
7.27.5; Air Ambulance	7.27.5.7(C)(4)	Expanded definition of Critical Care, and included “respiratory therapist” as an example of a provider “specifically trained in the area of care required”	Several public comments requested a clearer definition of critical care, and one comment requested that the definition of “critical care provider” include “respiratory therapist”
7.27.5; Air Ambulance	7.27.5.7(C)(5)	Clarified definition of Critical Care Provider	Public comment requested clarification of definition of “critical care provider”
7.27.5; Air Ambulance	7.27.5.7(S)(3)	Expanded definition of Specialty Care	Public comment requested clearer definition of Specialty Care
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7.27.5; Air Ambulance	7.27.5.13(A)(3)	Expanded description of Critical Care Ambulance Service	Public comment requested that expanded Critical Care definition be matched with better, clearer description of critical care ambulance

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7.27.5; Air Ambulance	7.27.5.13(D)	Added CAMTS to list of examples of bureau-approved accreditation services	Public comment requested inclusion of CAMTS
7.27.5; Air Ambulance	7.27.5.15(C)(10)	Clarified who may develop protocols to include the air ambulance advisory, and removed reference to the regional trauma advisory committee	Public comments from Air Advisory Committee and others
7.27.5; Air Ambulance	7.27.5.15(C)(27)	Clarified the EMS Bureau notification requirements, noting that accidents and “major” incidents are the requirement	Air advisory public comment that every “incident” would be overly burdensome
7.27.5; Air Ambulance	7.27.5.16(C)(3)(a-g)	Clarified who must be notified along with the CONCERN network about incidents, repeating that the EMS Bureau notification is for “major” incidents – not every incident. Identified those incidents that constitute “major incidents”	Public comment requested clarification regarding what constitutes a “major incident”
7.27.5; Air Ambulance	7.27.5.16 C(9)(g)	Removed word “tactical”, leaving only the word	Public comment that the term “tactical” has different

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		"processes"	2025 AUG 20 PM 12:33 connotation of intended by this usage
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14. The Department received a comment on behalf of the EMS Medical Direction Committee that recommended against the amendment to the Reciprocity rule 7.27.2.10(A) NMAC, which will allow an individual licensed in another state to apply for reciprocity if they meet the requirement (among various others) that, "if the applicant has joined an EMS agency as a volunteer or employee and this is verified by agency leadership, the agency's medical director may verify the applicant's competency in lieu of the applicant taking a bureau exam".

15. The Department believes that this amendment is appropriate, and that it could prove beneficial to EMS services and reciprocity applicants. The text was proposed by the Statewide Emergency Medical Services Advisory Committee to expedite the reciprocity application process. Although concerns were raised regarding potential liability or legal issues that might arise, this text would not *require* medical directors to verify an applicant's competency, but would instead allow them to do so. A medical director who is uncomfortable verifying an applicant's competency may opt against it.

16. The Department received a comment regarding 7.27.5.7 NMAC, proposing that the definition of "critical care provider" be revised to include "respiratory therapists". To address this, and rather than editing the definition of "critical care provider", the Department revised the definition of "critical care" at 7.27.5.7 NMAC to include respiratory therapist as an example of an "additional provider licensed at or above the ALS level of care or specifically trained in the area of care required".

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17. The Department received multiple public comments regarding 7.27.2.15(C)(10) NMAC, proposing that the Air Medical Transport Advisory Committee (AMTAC) make recommendations on standards for the Regional Trauma Advisory Councils (RETRACs) concerning air ambulance protocols, or proposing that the AMTAC should exclusively evaluate instances of alleged noncompliance by air ambulance services, rather than RETRACs.

18. In response, the Department revised 7.27.2.15(C)(10) NMAC to state, “Air ambulance certification may be denied, suspended, or revoked, or subject to other disciplinary action, based on the following grounds: ... (10) failure of a service to comply with a rotor wing response protocol or the fixed/rotor wing inter-facility transportation protocol *developed by the air medical transport advisory committee and implemented by a regional trauma advisory committee*, or any other bureau protocol or patient care-related policy as outlined in these rules”. (Emphasis added.) This text was included to acknowledge the respective roles of AMTAC and the RETRACs.

19. The Department received various public comments asserting that portions of the air ambulance enforcement rule section 7.27.5.15 NMAC were either too vague, too broad, or left too much discretion to the agency. However, the Department drafted those rule provisions broadly, to provide sufficient discretion to the agency to render case-by-case determinations.

20. For example, whether the conduct of air medical transport personnel constitutes a “significant threat to the health or safety of individuals receiving emergency care”, pursuant to 7.27.5.15(C)(19) NMAC, will vary depending on the facts and circumstances of each case. The Department cannot specify in the rule every scenario that could

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reasonably necessitate intervention by the EMS Bureau; and accordingly, the text of the rule must be broad to enable the agency sufficient discretion.

21. Similarly, whether repeated delays in transport of critical patients by an air medical transport provider warrants enforcement action under 7.27.5.15(B)(19)(b) NMAC will vary depending on individual facts and circumstances. The text as written provides NMDOH discretion to assess each incident according to individual facts and circumstances.

22. The Department received public comment regarding 7.27.5.15(D)(3) NMAC, requesting that the Department not deem air ambulance services ultimately responsible for the actions of their staff. Here again, the agency has discretion in determining whether to pursue disciplinary action in each case; but the Department believes that it is important that it be able to hold air ambulance services accountable for the actions of their staff.

23. The Department received public comment regarding the air ambulance hearings rule section 7.27.5.15(H) NMAC, expressing concern that a delay of up to 20 days leading up to a hearing on an immediate suspension would be harmful to licensees. While the Department understands the concern raised, it believes that the 20-day period is reasonable, and that a hearing conducted within 20 days would be sufficiently prompt.

24. This public comment included a request that the air ambulance service be allowed to continue its operations pending the outcome of a hearing. However, allowing continued operations in this situation would mean that the Department could never immediately suspend an air ambulance service's license. The Department must reserve the ability to immediately suspend a license if circumstances warrant it, particularly when

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an air ambulance service's continued operation would present a threat to the health and safety of the public.

25. The Department received public comments from the AMTAC and others, suggesting that the AMTAC could establish a Performance Improvement Committee (PIC) to play a role in evaluating the performance of a licensed air medical transport service. The Department did not include any revisions to the rule based on these proposals, firstly because the Department does not agree that the RETRAC should be divested of its role in evaluating the performance of air medical transport providers; but also because any such subcommittee of the RETRAC may be created outside of the rule.

26. The Department received comments concerning the Air Ambulance Licensing rule 7.27.5 NMAC, alleging that portions of the rule are preempted by the federal Airline Deregulation Act (ADA) of 1978, 49 U.S.C. 41713 *et seq.* The Department disagrees with those comments.

27. The ADA at 49 U.S.C. 41713 states in pertinent part that “a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.”

28. The provisions of 7.27.5 NMAC do not “relate[] to a price, route, or service of an air carrier” within the terms of 49 U.S.C. 41713, because they do not purport to regulate prices, routes, or types of services that may be offered by an air ambulance service. For this reason, the rule is not preempted.

29. The Secretary finds that the finished rules fall within the scope of the rulemaking proceeding, are a logical outgrowth of the notice given and comment received, and that

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members of the public were afforded a fair opportunity to present their views on the contents of the final plans. *See* 1.24.25.14(C) NMAC; *see also* N.M. Att’y Gen. Op. 87-59 (1987) (*citing* *BASF Wyandotte Corp. v. Costle*, 598 F.2d 637, 642 (1st Cir. 1979)); *see also* *Wylie Bros. Contracting Co. v. Albuquerque-Bernalillo Cty. Air Quality Control Bd.*, 1969-NMCA-089, ¶ 39, 80 N.M. 633, 642.

30. The Secretary finds that the Hearing Officer has appropriately considered the proposed rules and the public comments received, and finds that the recommendations of the Hearing Officer are reasonable and appropriate; and the Secretary adopts the Hearing Officer’s recommendations and incorporates the Hearing Officer’s Report and Recommendation by this reference.

31. The Secretary finds that the proposed rules are consistent with the statutory purposes of the New Mexico Department of Health, including but not limited to those expressed in the Department of Health Act, NMSA 1978, Section 9-7-3; the Emergency Medical Services Act, NMSA 1978, Section 24-10B-1 through -13; and the EMS Fund Act, NMSA 1978, Section 24-10A-1 through -10.

32. The Secretary further finds that the rule promulgation process satisfied the requirements of the State Rules Act, NMSA 14-4-1 through -11 and the New Mexico Attorney General’s Default Procedural Rule for Rulemaking at 1.24.25 NMAC.

33. The Secretary has familiarized herself with the rulemaking record, and finds that the proposed rules are appropriate and consistent with the authorizing law; and the proposed repeal and replacement of rules 7.27.2, 7.27.4, 7.27.5, 7.27.6, and 7.27.11 NMAC is hereby adopted.

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NEW MEXICO DEPARTMENT OF HEALTH

Signed by:

Gina DeBlassie

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Gina DeBlassie

Cabinet Secretary

Aug 26, 2025 | 9:46 AM MDT

Date

The New Mexico Department of Health approved the repeal of its rule 7.27.11 NMAC - Supplemental Licensing Provisions (filed 11/30/2017) and replaced it with 7.27.11 NMAC - Supplemental Licensing Provisions, adopted on 8/26/2025, and effective 9/9/2025.

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Issuing agency name and address: Agency DFA code:

Contact person's name: Phone number: E-mail address:

Type of rule action: New Amendment Repeal Emergency Renumber (ALD Use) Recent filing date:

Title number: Title name:

Chapter number: Chapter name:

Part number: Part name:

Amendment description (If filing an amendment):

Amendment's NMAC citation (If filing an amendment):

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Concise Explanatory Statement For Rulemaking Adoption:

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- Reasons for any change between the published proposed rule and the final rule; and
- Reasons for not accepting substantive arguments made through public comment.

See Statement of Reasons for Adoption, attached.

Issuing authority (If delegated, authority letter must be on file with ALD):

Name:

Christopher D Woodward

Check if authority has been delegated

Title:

Assistant General Counsel

Signature: (BLACK ink only OR Digital Signature)

Date signed:

Christopher
Woodward

Digitally signed by Christopher
Woodward
Date: 2025.08.28 11:53:08 -06'00'

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**STATE OF NEW MEXICO
BEFORE THE SECRETARY OF HEALTH**

**IN THE MATTER OF PROPOSED
REPEAL AND REPLACEMENT OF
7.27.2, 7.27.4, 7.27.5, 7.27.6, AND
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**STATEMENT OF REASONS
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7.27.4, 7.27.5, 7.27.6, AND 7.27.11 NMAC**

The Cabinet Secretary for the New Mexico Department of Health, Gina DeBlassie (“Secretary”), adopts the proposed repeal and replacement of parts 7.27.2, 7.27.4, 7.27.5, 7.27.6, and 7.27.11 NMAC, for the reasons stated below. This decision is based on the rulemaking record in this matter, which includes Exhibits 1 through 24, the recording of the hearing, and the Report and Recommendation of the Hearing Officer, Jared Najjar, dated July 14, 2025.

In support of this action, the Secretary finds the following:

1. The Department of Health (“Department”) is authorized to promulgate regulations as may be necessary to carry out the duties of the Department and its divisions. NMSA 1978, Section 9-7-6(E).
2. Pursuant to the Emergency Medical Services Act (EMS Act) at NMSA 1978, § 24-10B-5, the Department is responsible for adopting licensing requirements for all persons who provide emergency medical services within the state of New Mexico, irrespective of whether the services are remunerated.
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4. By letter dated April 14, 2025, the Secretary designated Mr. Najjar to serve as hearing officer for the purpose of conducting the hearing and submitting a recommendation regarding the proposed rule. Exhibit 22.

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reasonably necessitate intervention by the EMS Bureau; and accordingly, the text of the rule must be broad to enable the agency sufficient discretion.

21. Similarly, whether repeated delays in transport of critical patients by an air medical transport provider warrants enforcement action under 7.27.5.15(B)(19)(b) NMAC will vary depending on individual facts and circumstances. The text as written provides NMDOH discretion to assess each incident according to individual facts and circumstances.

22. The Department received public comment regarding 7.27.5.15(D)(3) NMAC, requesting that the Department not deem air ambulance services ultimately responsible for the actions of their staff. Here again, the agency has discretion in determining whether to pursue disciplinary action in each case; but the Department believes that it is important that it be able to hold air ambulance services accountable for the actions of their staff.

23. The Department received public comment regarding the air ambulance hearings rule section 7.27.5.15(H) NMAC, expressing concern that a delay of up to 20 days leading up to a hearing on an immediate suspension would be harmful to licensees. While the Department understands the concern raised, it believes that the 20-day period is reasonable, and that a hearing conducted within 20 days would be sufficiently prompt.

24. This public comment included a request that the air ambulance service be allowed to continue its operations pending the outcome of a hearing. However, allowing continued operations in this situation would mean that the Department could never immediately suspend an air ambulance service's license. The Department must reserve the ability to immediately suspend a license if circumstances warrant it, particularly when

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an air ambulance service's continued operation would present a threat to the health and safety of the public.

25. The Department received public comments from the AMTAC and others, suggesting that the AMTAC could establish a Performance Improvement Committee (PIC) to play a role in evaluating the performance of a licensed air medical transport service. The Department did not include any revisions to the rule based on these proposals, firstly because the Department does not agree that the RETRAC should be divested of its role in evaluating the performance of air medical transport providers; but also because any such subcommittee of the RETRAC may be created outside of the rule.

26. The Department received comments concerning the Air Ambulance Licensing rule 7.27.5 NMAC, alleging that portions of the rule are preempted by the federal Airline Deregulation Act (ADA) of 1978, 49 U.S.C. 41713 *et seq.* The Department disagrees with those comments.

27. The ADA at 49 U.S.C. 41713 states in pertinent part that “a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.”

28. The provisions of 7.27.5 NMAC do not “relate[] to a price, route, or service of an air carrier” within the terms of 49 U.S.C. 41713, because they do not purport to regulate prices, routes, or types of services that may be offered by an air ambulance service. For this reason, the rule is not preempted.

29. The Secretary finds that the finished rules fall within the scope of the rulemaking proceeding, are a logical outgrowth of the notice given and comment received, and that

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members of the public were afforded a fair opportunity to present their views on the contents of the final plans. *See* 1.24.25.14(C) NMAC; *see also* N.M. Att’y Gen. Op. 87-59 (1987) (*citing BASF Wyandotte Corp. v. Costle*, 598 F.2d 637, 642 (1st Cir. 1979)); *see also Wylie Bros. Contracting Co. v. Albuquerque-Bernalillo Cty. Air Quality Control Bd.*, 1969-NMCA-089, ¶ 39, 80 N.M. 633, 642.

30. The Secretary finds that the Hearing Officer has appropriately considered the proposed rules and the public comments received, and finds that the recommendations of the Hearing Officer are reasonable and appropriate; and the Secretary adopts the Hearing Officer’s recommendations and incorporates the Hearing Officer’s Report and Recommendation by this reference.

31. The Secretary finds that the proposed rules are consistent with the statutory purposes of the New Mexico Department of Health, including but not limited to those expressed in the Department of Health Act, NMSA 1978, Section 9-7-3; the Emergency Medical Services Act, NMSA 1978, Section 24-10B-1 through -13; and the EMS Fund Act, NMSA 1978, Section 24-10A-1 through -10.

32. The Secretary further finds that the rule promulgation process satisfied the requirements of the State Rules Act, NMSA 14-4-1 through -11 and the New Mexico Attorney General’s Default Procedural Rule for Rulemaking at 1.24.25 NMAC.

33. The Secretary has familiarized herself with the rulemaking record, and finds that the proposed rules are appropriate and consistent with the authorizing law; and the proposed repeal and replacement of rules 7.27.2, 7.27.4, 7.27.5, 7.27.6, and 7.27.11 NMAC is hereby adopted.

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NEW MEXICO DEPARTMENT OF HEALTH

Signed by:

Gina DeBlassie

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Gina DeBlassie
Cabinet Secretary

Aug 26, 2025 | 9:46 AM MDT

Date

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TITLE 7 HEALTH
CHAPTER 27 EMERGENCY MEDICAL SERVICES
PART 11 SUPPLEMENTAL LICENSING PROVISIONS

7.27.11.1 ISSUING AGENCY: New Mexico Department of Health (DOH), emergency medical systems bureau (EMSB).

[7.27.11.1 NMAC - Rp, 7.27.11.1 NMAC, 9/9/2025]

7.27.11.2 SCOPE: These rules apply to New Mexico emergency medical services (EMS), including mobile integrated health, community EMS, critical care EMS, special event, healthcare facilities, and other entities that employ and utilize New Mexico licensed EMS personnel. These rules also apply to the service directors and medical directors of those services; approved New Mexico emergency medical service (EMS) training programs and graduates of approved New Mexico EMS training programs; New Mexico licensed EMS personnel including those previously licensed; persons trained, certified or licensed in another state or territory, or certified by the national registry of emergency medical technicians, seeking to acquire licensure in New Mexico; EMS licensing commission; and any other entity associated with the licensing of emergency medical services personnel in New Mexico. In the event of a public health emergency that stresses the emergency medical service system and disrupts delivery of medical services, the New Mexico department of health, working with the emergency medical systems bureau, may limit or expand these rules, and may institute certain crisis standards of care, through emergency rulemaking.

[7.27.11.2 NMAC - Rp, 7.27.11.2 NMAC, 9/9/2025]

7.27.11.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to the following statutory authorities: the New Mexico Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to “make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions,” and the Emergency Medical Services Act, Section 24-10B-4 NMSA 1978 (“bureau; duties”).

[7.27.11.3 NMAC - Rp, 7.27.11.3 NMAC, 9/9/2025]

7.27.11.4 DURATION: Permanent.

[7.27.11.4 NMAC - Rp, 7.27.11.4 NMAC, 9/9/2025]

7.27.11.5 EFFECTIVE DATE: September 9, 2025, unless a later date is cited at the end of a section.

[7.27.11.5 NMAC - Rp, 7.27.11.5 NMAC, 9/9/2025]

7.27.11.6 OBJECTIVE: These rules are intended to supplement the emergency medical services licensure requirements for emergency medical services personnel, to provide supplemental and additional standards for the licensure of emergency medical dispatchers, emergency medical dispatch-instructors, emergency medical services first responders and emergency medical technicians, and to assist in the provision of a comprehensive system of emergency medical services in the state of New Mexico.

[7.27.11.6 NMAC - Rp, 7.27.11.6 NMAC, 9/9/2025]

7.27.11.7 DEFINITIONS: Refer to 7.27.2.7 NMAC.

[7.27.11.7 NMAC - Rp, 7.27.11.7 NMAC, 9/9/2025]

7.27.11.8 SCOPES OF PRACTICE FOR LICENSED EMERGENCY MEDICAL SERVICES PERSONNEL:

A. Medical director means a physician functioning as the service EMS medical director as defined and described in 7.27.3 NMAC, medical direction for emergency medical services. Medical control means supervision provided by or under the direction of a physician.

B. Prior to approving a new skill, technique, medication, or procedure, it shall be documented by the service director, medical director, or approved EMS training institution that the EMS provider has been appropriately trained to perform those new skills, techniques, medications, or procedures.

C. Service medical director approved: All service medical director approved skills, techniques, medications, or procedures are considered advanced life support. Prior to utilizing any skill, technique, medication or procedure designated as service medical director approved, it shall be documented by the service director,

medical director, or approved EMS training institution that the EMS provider has been appropriately trained to administer the medications or perform the skills, techniques, medications or procedures. Additionally, each EMS provider must have a signed authorization from the service's medical director on file at the EMS service's headquarters or administrative offices.

D. Any device in an EMS agency's treatment guideline/protocol designed and utilized to facilitate successful completion of a skill or other treatment modality, including but not limited to cardiopulmonary resuscitation (CPR) devices, intraosseous placement devices, and positive pressure ventilation devices, must be approved by the service medical director.

E. Wilderness protocols: The following skills shall only be used by providers who have a current wilderness certification from a bureau approved wilderness caregiver course, who are functioning in a wilderness environment as a wilderness provider (an environment in which time to a hospital is expected to exceed two hours, except in the case of an anaphylactic reaction, in which no minimum transport time is required), and are authorized by their medical director to provide the treatment:

- (1) minor wound cleaning and management;
- (2) cessation of CPR;
- (3) field clearance of the cervical-spine;
- (4) reduction of dislocations resulting from indirect force of the patella, digit, and anterior

shoulder.

F. Community emergency medical services and mobile integrated health programs:

Community EMS (CEMS) and mobile integrated health (MIH) programs shall be provided by EMS caregivers who, after completing a bureau approved CEMS/MIH caregiver course, are functioning as part of a program that has been reviewed and approved by the EMS bureau. The providers must be authorized by their medical director to perform the skills listed in their application as part of the program. These programs may include referrals that involve transport to non-hospital locations, and for non-transport decisions. Skills and interventions may include any of the approved skills and interventions for the appropriate level; any skill that exceeds the scope of practice must be approved through the special skill process. Skills may include, but are not limited to:

- (1) education of patients in self-medication administration, and assessment of compliance with physician recommendations for health conditions;
- (2) assessments for preventing falls and other sources of injury by identifying risks in patient homes;
- (3) provide education on disease prevention;
- (4) administering immunizations;
- (5) in collaboration with a healthcare team, assist in developing a care plan, and educate the patient in following the care plan;
- (6) perform in home patient assessments commensurate with level of education and licensure and facilitate telemedicine clinician contact if available in order to provide information to a care team as to the progress or condition of a patient receiving therapies for medical conditions;
- (7) provide assistance in locating and contacting appropriate providers of needed social services;
- (8) treat discovered acute healthcare issues, transporting to emergency department if necessary;
- (9) for chronic and non-acute issues, confirmed with online medical direction and agreed to by the patient, options other than EMS transport may be considered, including:
 - (a) arrange for non-emergent and non-EMS transportation to and care at an appropriate facility, such as a physician's office or urgent care center;
 - (b) provide referral information and arrange for follow up by appropriate care team members or social service personnel; and
- (10) assist with ongoing prescribed wound care.

G. Critical care transport services skills: Paramedic critical care transport skills shall be used only by paramedic providers who have successfully completed a bureau approved critical care transport paramedic or critical care flight paramedic course. Subsequent to completing the approved course, the critical care paramedic must successfully complete a bureau administered or approved third party exam within one year. Additionally, the paramedics shall be functioning as part of a ground or air EMS agency with an approved critical care transport special skill and authorized by the agency medical director to utilize these skills. Critical care transport program skills are only authorized for use during inter-facility critical care transport activities, with the exception of air ambulance agencies providing emergency scene response; or ground critical care agencies requested to a scene by

the local authorized and certified 911 response and transport agencies. Critical care transport special skills and medications that may be administered include, but are not limited to any of the below skills and medications; service specific skills and medication requests must be listed on the EMS agency critical care transport special skill application completed per 7.27.11.10 NMAC:

(1) monitoring of infusions including but not limited to anti-arrhythmics, nitrates, vasopressors, blood products, thrombolytics, sedation, pain management and antihypertensive medications that have required titration within the past two hours and may need to have their dosages adjusted during transport;

(2) performance of skills not listed in the paramedic scope of practice, such as but not limited to escharotomy, fasciotomy, insertion of chest tubes, pericardiocentesis, blood administration, and nerve blocks; administration of medications, initiation of infusions, and utilization of routes, not listed on the paramedic scope but requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau;

(3) utilization of advanced patient monitoring, such as invasive hemodynamic monitoring via monitoring of central venous pressure, pulmonary artery pressure, intracranial pressure monitoring, Swan-Ganz catheters, arterial lines, fetal monitoring, point of care lab values, and other monitoring or tests not listed in the paramedic scope, but requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau;

(4) utilization of intensive care unit (ICU) level ventilator support, to include ventilators delivering positive end expiratory pressure, with multiple adjustable mode and setting parameters that include inspiratory plateau pressures, pressure regulated volume control, pressure support ventilation, pressure control ventilation, airway pressure release ventilation and others; also, any ventilator delivering a mixture of nitric oxide or other beneficial gas mixtures;

(5) transport of patients with intra-aortic balloon pump, temporary internal cardiac pacing, left ventricular assist device or a bi-ventricular assist device and other appropriate devices to address hemodynamic instability as requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau;

(6) administer paralytics and sedatives to maintain airway control previously initiated, and administer and perform rapid sequence airway pharmacology and techniques in order to secure an airway in response to patient condition, as requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau;

(7) pediatric intubation or endotracheal tube management as requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau.

H. Utilization of pharmacological agents for the primary purpose of sedation, induction, or muscle relaxation to facilitate placement of an advanced airway requires medical direction committee special skills approval.

I. **Over the counter (OTC) medications and products:** A physician medical director may approve a list of over the counter (OTC) medications and products (i.e. NSAID's, antihistamines, anti-diarrheal, laxatives, antacids, vitamin supplements, hygiene products and other products) for distribution by an EMS caregiver working under medical direction to a requesting individual during scheduled stand-by situations. Examples are long-term wildfire responses, public events (concerts, rodeos, etc.), various industry situations such as movie production and ski patrol, long-term construction & manufacturing projects, long-term search and rescue or tactical operations, and other situations where scheduled stand-by EMS is provided.

(1) The OTC medication/product must be properly labeled in individual dose packaging when distributed to the patient. Distribution from a bulk or multi-dose container is not permitted by this scope of practice, as well as other state and federal laws and regulations; medications will be distributed per manufacturer recommendations and labeling directions.

(2) The agency/EMS caregiver will maintain a written guideline that contains the list of physician approved OTC medications/products and the conditions for which they may be distributed. Specific dosing information and indications for pediatric patients must be included.

(3) The EMS agency/EMS caregiver must develop a method of documentation for the appropriate distribution of the OTC medications/products. This documentation shall include the OTC medication documentation and appropriate patient care report, per 7.27.10.12 NMAC (records and data collection) and 7.27.11.11 NMAC. Public regulation commission (PRC) certified ambulance agencies shall complete patient care documentation per 18.3.14.22 NMAC.

(4) OTC medications/products are distributed for the patient's self-administration and use. EMS caregivers will not administer OTC medications/products, unless approved elsewhere in the scope of practice

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for specific EMS patient care situations.

J. Licensed emergency medical dispatcher (EMD):

(1) Medical direction is required for all items in the EMD scope of practice of practice.
 (2) The following allowable skills may be performed by EMDs who are licensed by the EMS bureau and functioning with an EMS bureau certified New Mexico emergency medical dispatch agency utilizing protocols and any EMD priority reference system approved by the EMS bureau and service medical director.

- (a) Process calls for medical assistance in a standardized manner, eliciting required information for evaluating, advising, and treating sick or injured individuals, and dispatching an appropriate EMS response.
- (b) Provide pre-arrival instructions to the patient through the caller when possible and appropriate to do so while functioning in compliance with an emergency medical dispatch priority reference system (EMDPRS).

K. EMS first responders (EMSFR):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

- (a) basic airway management;
- (b) use of basic adjunctive airway equipment;
- (c) suctioning;
- (d) cardiopulmonary resuscitation, according to current ECC guidelines;
- (e) obstructed airway management;
- (f) bleeding control via direct pressure and appropriate tourniquet use;
- (g) spinal motion restriction;
- (h) splinting (does not include femoral traction splinting);
- (i) scene assessment, triage, scene safety;
- (j) use of statewide EMS communications system;
- (k) emergency childbirth;
- (l) glucometry;
- (m) oxygen;
- (n) other non-invasive procedures as taught in first responder courses adhering to

United States Department of Transportation curricula.

(2) The following require service medical director approval:

- (a) allowable skills:
 - (i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FiO2, and pressure relief/alarm and does not have multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation via continuous positive airway pressure (CPAP);
 - (ii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;
 - (iii) hemostatic dressings for control of bleeding;
 - (iv) insertion of laryngeal and supraglottic airway devices (examples: king airway, LMA), excluding multi-lumen airways).
- (b) administration of approved medications via the following routes:
 - (i) nebulized inhalation;
 - (ii) nasal mucosal atomization (MA);
 - (iii) intramuscular or subcutaneous;
 - (iv) oral (PO).
- (c) allowable drugs:
 - (i) oral glucose preparations;
 - (ii) aspirin PO for adults with suspected cardiac chest pain;
 - (iii) atropine and pralidoxime via IM auto-injection for treatment of chemical or nerve agent exposure;
 - (iv) albuterol (including isomers) via inhaled administration;
 - (v) naloxone via nasal mucosal atomizer;
 - (vi) epinephrine, 1:1000, no single dose greater than 0.3 ml, subcutaneous or intramuscular injection with a pre-measured syringe (including autoinjector) or 0.3 ml TB syringe for anaphylaxis

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or status asthmaticus refractory to other treatments.

- (d) patient's own medication that may be administered:
 - (i) bronchodilators using pre-measured or metered dose inhalation device;
 - (ii) naloxone, if provided with a nasal MA or IM delivery system.

L. EMT-Basic (EMT-B):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

- (a) basic airway management;
- (b) use of basic adjunctive airway equipment;
- (c) suctioning;
- (d) cardiopulmonary resuscitation, according to current ECC guidelines;
- (e) obstructed airway management;
- (f) bleeding control to include appropriate tourniquet usage;
- (g) spinal motion restriction;
- (h) splinting;
- (i) scene assessment, triage, scene safety;
- (j) use of statewide EMS communications system;
- (k) childbirth (imminent delivery);
- (l) glucometry;
- (m) oxygen;
- (n) other non-invasive procedures as taught in EMT-B courses adhering to DOT

curricula;

- (o) wound management.

(2) The following require service medical director approval:

- (a) allowable skills:
 - (i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, fraction of inspired oxygen (FiO₂) and pressure relief/alarm and does not have multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation via continuous positive airway pressure (CPAP);

(examples: PTLA, combi-tube, king airway, LMA) to include gastric suctioning;

(iii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;

- (iv) acupressure;
- (v) transport of patients with gastric tubes, urinary catheters, heparin/saline

locks, PEG tubes, or vascular access devices intended for outpatient use;

(vi) performing point of care testing; examples include serum lactate values, cardiac enzymes, electrolytes, and other diagnostic values;

- (vii) hemostatic dressings for control of bleeding.

(b) administration of approved medications via the following routes:

- (i) nebulized inhalation;
- (ii) subcutaneous;
- (iii) intramuscular;
- (iv) nasal mucosal atomization (MA);
- (v) oral (PO);
- (vi) intradermal.

(c) allowable drugs:

- (i) oral glucose preparations;
- (ii) aspirin PO for adults with suspected cardiac chest pain;
- (iii) activated charcoal PO;
- (iv) acetaminophen PO;
- (v) ondansetron PO;
- (vi) atropine and pralidoxime via IM autoinjection for treatment of

chemical or nerve agent exposure.

- (vii) albuterol (including isomers), via inhaled administration;

(viii) ibuprofen PO in pediatric or adults to treat fever or pain;
(ix) ipratropium, via inhaled administration, in combination with or after albuterol administration;
(x) naloxone by SQ, IM, or IN route;
(xi) epinephrine, 1:1000, no single dose greater than 0.3 ml, subcutaneous or intramuscular injection with a pre-measured syringe (including autoinjector) or 0.3 ml TB syringe for anaphylaxis or status asthmaticus refractory to other treatments.

(d) patient's own medication that may be administered:
(i) bronchodilators using pre-measured or metered dose inhalation device;
(ii) sublingual nitroglycerin for unrelieved chest pain, with on line medical

control only;
(iii) situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance in airway management appropriate to their level of licensure, and administer the patient's prescribed medications where appropriate only if the medication is in the EMS provider's scope of practice; EMS services are not expected to provide the prescribed medications for these special needs patients.

(3) **Immunizations and biologicals:** Administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:

(a) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;

(b) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;

(c) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of pharmaceuticals or tests not listed above.

M. EMT-Intermediate (EMT-I):

(1) **The following allowed drugs may be administered and skills and procedures may be performed without medical direction:**

- (a) basic airway management;
- (b) use of basic adjunctive airway equipment;
- (c) suctioning;
- (d) cardiopulmonary resuscitation, according to ECC guidelines;
- (e) obstructed airway management;
- (f) bleeding control including appropriate use of tourniquet;
- (g) spinal motion restriction;
- (h) splinting;
- (i) scene assessment, triage, scene safety;
- (j) use of statewide EMS communications system;
- (k) childbirth (imminent delivery);
- (l) glucometry;
- (m) oxygen;
- (n) wound management.

(2) **The following require service medical director approval:**

(a) allowable skills:
(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FIO₂, and pressure relief/alarm and does not have multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation via continuous positive airway pressure (CPAP);

(ii) use of multi-lumen, supraglottic, and laryngeal airway devices (examples: PTLA, combi-tube, king airway, LMA) to include gastric suctioning;

(iii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;

- (iv) acupressure;
- (v) transport of patients with gastric tubes, urinary catheters, heparin/saline locks, PEG tubes, or vascular access devices intended for outpatient use;
- (vi) peripheral venous puncture/access;
- (vii) blood drawing;
- (viii) intraosseous access for patients eight years old and older; for patients seven years old or younger, only proximal tibia and distal femur sites may be used;
- (ix) adult intraosseous access;
- (x) point of care testing; examples include serum lactate values, cardiac enzymes, electrolytes, and other diagnostic values;
- (xi) hemostatic dressings for control of bleeding.
- (b) administration of approved medications via the following routes:
 - (i) intravenous;
 - (ii) nasal mucosal atomization (MA);
 - (iii) nebulized inhalation;
 - (iv) sublingual;
 - (v) intradermal;
 - (vi) intraosseous;
 - (vii) oral (PO);
 - (viii) intramuscular;
 - (ix) subcutaneous.
- (c) allowable drugs:
 - (i) oral glucose preparations;
 - (ii) aspirin PO for adults with suspected cardiac chest pain;
 - (iii) activated charcoal PO;
 - (iv) acetaminophen;
 - (v) ibuprofen PO to pediatrics and adults for pain or fever; IV or IM ketorolac for pain;
 - (vi) IM autoinjection of the following agents for treatment of chemical or nerve agent exposure: atropine, pralidoxime;
 - (vii) albuterol (including isomers) via inhaled administration;
 - (viii) ipratropium, via inhaled administration in combination with or after albuterol administration;
 - (ix) naloxone;
 - (x) I.V. fluid therapy (except blood or blood products);
 - (xi) tranexamic acid; for patients >15 years of age with traumatic hemorrhagic shock or post-partum bleeding; for patients 15 years of age or less, MCEP order must be obtained for approval and dosing;
 - (xii) oxytocin for post-partum patients;
 - (xiii) dextrose;
 - (xiv) epinephrine (1:1000), SQ or IM (including autoinjector) for anaphylaxis and known asthmatics in severe respiratory distress (no single dose greater than 0.3 cc);
 - (xv) epinephrine (1:10,000) in pulseless cardiac arrest for both adult and pediatric patients; epinephrine may be administered via the endotracheal tube in accordance with most current ACLS and PALS guidelines;
 - (xvi) nitroglycerin (sublingual); must have intravenous access established prior to administration or approval of online medical control if IV access is unavailable;
 - (xvii) morphine, fentanyl, or dilaudid for use in pain control with approval of on-line or off-line (written protocol) medical control;
 - (xviii) diphenhydramine for allergic reactions or dystonic reactions;
 - (xix) glucagon, to treat hypoglycemia in diabetic patients when intravenous access is not obtainable;
 - (xx) anti-emetic agents, for use as an anti-emetic only;
 - (xxi) corticosteroids for respiratory illness or allergic reaction;
 - (xxii) hydroxycobalamine;
 - (xxiii) lidocaine two percent, preservative and epinephrine free for IV use) for

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administration into the intraosseous space on pain responsive adult patients while receiving intraosseous fluids or medications.

- (d) patient's own medication that may be administered:
 - (i) bronchodilators using pre-measured or metered dose inhalation device;
 - (ii) sublingual nitroglycerin for unrelieved chest pain; must have

intravenous access established prior to administration or approval of online medical control if IV access is unavailable;

- (iii) glucagon;
- (iv) situations may arise involving patients with uncommon conditions

requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance in airway management appropriate to their level of licensure, IV access, and the administration of the patient's prescribed medications where appropriate only if the medication is in the EMS provider's scope of practice; online (direct contact) medical control communication must be established with the medical control physician approving the intervention; EMS services are not expected to provide the prescribed medications for these special needs patients.

- (e) drugs allowed for monitoring during interfacility transport:

- (i) potassium; intermediate EMT's may monitor IV solutions that contain potassium during transport (not to exceed 20 mEq/1000cc or more than 10 mEq/hour);

- (ii) antibiotics and other anti-infectives utilizing an infusion pump; intermediate EMT's may monitor antibiotic or other anti-infective agents, provided a hospital-initiated infusion has been running for a minimum of 30 minutes prior to the intermediate initiating the transfer, and the intermediate EMT is aware of reactions for which to monitor and the appropriate action to take before assuming responsibility for patient care.

- (f) immunizations and biologicals: administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:

- (i) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;

- (ii) administer vaccines to EMS and public safety personnel;
- (iii) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;

- (iv) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of pharmaceuticals or tests not listed above.

N. EMT-Paramedic (EMT-P):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

- (a) basic airway management;
- (b) use of basic adjunctive airway equipment;
- (c) suctioning;
- (d) cardiopulmonary resuscitation, according to current ECC guidelines;
- (e) obstructed airway management;
- (f) bleeding control including the appropriate use of tourniquet;
- (g) spinal motion restriction;
- (h) splinting;
- (i) scene assessment, triage, scene safety;
- (j) use of statewide EMS communications system;
- (k) childbirth (imminent delivery);
- (l) glucometry;
- (m) oxygen;
- (n) wound management.

(2) The following require service medical director approval:

- (a) allowable skills:
 - (i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FiO₂, and pressure relief/alarm and has multiple automatic ventilation modes;

this skill includes devices that provide non-invasive positive pressure ventilation (including continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BPAP);

(ii) use of multi-lumen, supraglottic, and laryngeal airway devices
(examples: PTLA, combi-tube, king airway, LMA) to include gastric suctioning;
(iii) transport of patients with gastric tubes, urinary catheters, heparin/saline locks, PEG tubes, or vascular access devices;

(iv) application and use of semi-automatic defibrillators;
(v) acupressure;
(vi) peripheral venous puncture/access;
(vii) blood drawing;
(viii) I.V. fluid therapy;
(ix) direct laryngoscopy for endotracheal intubation and removal of foreign body in patients 13 and older; for patients 12 and under, for removal of foreign body only;

(x) endotracheal intubation for patients over the age of 12;
(xi) thoracic decompression (needle thoracostomy);
(xii) surgical cricothyroidotomy;
(xiii) insertion of gastric tubes;
(xiv) cardioversion and manual defibrillation;
(xv) external cardiac pacing;
(xvi) cardiac monitoring;
(xvii) use of infusion pumps;
(xviii) initiation of blood and blood products; must have online medical control for patients under 12 years old;

(xix) intraosseous access;
(xx) performing point of care testing; examples include serum lactate values, cardiac enzymes, electrolytes, and other diagnostic values;

(xxi) hemostatic dressings for control of bleeding;
(xxii) vagal maneuvers.

(b) administration of approved medications via the following routes:

- (i) intravenous;
- (ii) nasal mucosal atomization (MA);
- (iii) nebulized inhalation;
- (iv) sublingual;
- (v) intradermal;
- (vi) intraosseous;
- (vii) oral (PO);
- (viii) intramuscular;
- (ix) topical;
- (x) rectal;
- (xi) IV drip;
- (xii) subcutaneous.

(c) allowable drugs:

- (i) acetaminophen;
- (ii) activated charcoal;
- (iii) adenosine;
- (iv) albuterol (including isomers);
- (v) amiodarone;
- (vi) aspirin;
- (vii) atropine sulfate;
- (viii) benzodiazepines;
- (ix) blood and blood products;
- (x) calcium preparations;
- (xi) corticosteroids;
- (xii) dextrose;
- (xiii) diphenhydramine;
- (xiv) epinephrine;

- (xv) furosemide;
- (xvi) glucagon;
- (xvii) hydroxycobalamine;
- (xviii) ipratropium;
- (xix) lidocaine;
- (xx) magnesium sulfate;
- (xxi) naloxone;
- (xxii) narcotic analgesics;
- (xxiii) nitroglycerin;
- (xxiv) nonsteroidal anti-inflammatory drugs (NSAIDS) to pediatric or adult patients with pain or fever;
- (xxv) oral glucose preparations;
- (xxvi) oxytocin;
- (xxvii) phenylephrine nasal spray;
- (xxviii) pralidoxime, IM auto-injection for treatment of chemical and nerve agent exposure;
- (xxix) anti-emetic agents, for use as an anti-emetic only;
- (xxx) sodium bicarbonate;
- (xxxi) thiamine;
- (xxxii) topical anesthetic ophthalmic solutions;
- (xxxiii) tranexamic acid for patients >15 years of age;
- (xxxiv) vasopressor agents;
- (xxxv) intravenous fluids;
- (xxxvi) haloperidol, droperidol, and olanzapine for chemical restraint in agitated patients.

(3) **Drugs allowed for monitoring during inter-facility transports:** (initiated and administered by the sending facility with defined dosing parameters and requiring an infusion pump when given by continuous infusion unless otherwise specified); any titration of one of these medications outside of the predefined dosing parameters requires online physician medical control:

- (a) potassium (no infusion pump needed if concentration not greater than 20mEq/1000cc;
- (b) anticoagulation type blood modifying agents (such as fibrolytic drugs, heparin, glycoprotein IIb-IIIa inhibitors/antagonists);
- (c) procainamide;
- (d) mannitol;
- (e) aminophylline;
- (f) antibiotics and other anti-infective agents;
- (g) sodium nitroprusside;
- (h) insulin;
- (i) terbutaline;
- (j) octreotide;
- (k) nutritional supplements;
- (l) beta blockers;
- (m) calcium channel blockers;
- (n) dobutamine;
- (o) nesiritide;
- (p) propofol in patients that are intubated prior to transport;
- (q) proton pump inhibitors and H2 antagonists;
- (r) crotalidae polyvalent immune fab (ovine) ("crofab") or anavip (crotalidae

immune fab2 (equine)); either may be monitored during inter-facility transport provided the facility-initiated infusion has been running for a minimum of 30 minutes prior to the paramedic initiating the transfer and assuming responsibility for patient care;

(s) medications not otherwise covered by scope of practice, in limited circumstances: infrequent interfacility transport situations may arise where a patient may be receiving medications not covered by scope of practice, and appropriate hospital caregivers are not available to accompany or transfer the patient. If the sending and receiving physician agree, and with the service medical director's approval, the paramedic

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may transfer the patient to the appropriate receiving facility, aircraft, or ground unit. The sending physician must provide the appropriate briefing on the specific medication, effects, assessment and monitoring requirements, potential adverse reactions, and rescue interventions. The paramedic has the right to refuse the transport if not adequately briefed by the sending physician or otherwise not comfortable monitoring the medication.

(4) **Immunizations and biologicals:** administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:

- (a) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;
- (b) administer vaccines to EMS and public safety personnel;
- (c) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;
- (d) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of other pharmaceuticals or tests not listed above.

(5) **Skills approved for monitoring in transport:**

- (a) internal cardiac pacing;
- (b) chest tubes.

(6) **Medications for administration during patient transfer:**

- (a) retavase (second dose only);
- (b) protamine sulfate;
- (c) non-depolarizing neuromuscular blocking agents in patients that are intubated

prior to transport;

(d) acetylcysteine.

(7) **Patient's own medication that may be administered:**

(a) epoprostenol sodium, treprostinil sodium, or other medications utilized for certain types of pulmonary hypertension;

(b) bronchodilators using pre-measured or metered dose inhalation device;

(c) sublingual nitroglycerin for unrelieved chest pain; must have intravenous access established prior to administration;

(d) glucagon;

(e) situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance in airway management appropriate to their level of licensure, IV access, and the administration of the patient's prescribed medications where appropriate only if the medication is in the EMS provider's scope of practice; online (direct contact) medical control communication must be established with the medical control physician approving the intervention; EMS services are not expected to provide the prescribed medications for these special needs patients.

[7.27.11.8 NMAC - Rp, 7.27.11.8 NMAC, 9/9/2025]

7.27.11.9 APPROVED TRAINING PROGRAMS: "Approved emergency medical services training program" means a New Mexico emergency medical services training program that is sponsored by a post-secondary educational institution, is accredited by a bureau approved national accrediting organization for emergency medical services or active in the accreditation process, and is approved by the joint organization on education (JOE) and participates in the joint organization on education. Currently, there are 7 approved EMS training programs. However, additional programs may attain accreditation and JOE approval prior to this rule being updated.

A. Emergency medical services academy: University of New Mexico, (700 Camino De Salud NE., Albuquerque, New Mexico 87106, Tel: 505-272-5757). The EMS academy is designated as the lead training agency for providers in New Mexico as stated in Section 24-10B-12 NMSA 1978. The EMS academy teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

B. Dona Ana community college: New Mexico state university, (Box 30001, Las Cruces, NM 88003-8001, Tel: 505-527-7530). Dona Ana community college teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

C. Eastern New Mexico university: EMS program, (Box 6000, Roswell, NM 88202-6000, Tel: 505-624-7000). The eastern New Mexico university teaches formal EMS education courses including EMS first

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responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

D. Central New Mexico community college: EMS program, (525 Buena Vista Albuquerque, NM 87106, Tel: 505-224-4000). Central New Mexico community college teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

E. San Juan college EMS program: (4601 College Blvd; Farmington, NM 87402; 505-566-3857). San Juan College conducts formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

F. Santa Fe community college: EMS Program, (6401 Richards Ave, Santa Fe, NM 87508, 505-428-1820) SFCC conducts formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

G. Clovis community college EMS program: (417 Schepps Blvd., Clovis, NM 88101 575-769-4976). Clovis Community College conducts formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

[7.27.11.9 NMAC - Rp, 7.27.11.9 NMAC, 9/9/2025]

7.27.11.10 SPECIAL SKILLS APPLICATION AND REPORTING PROCEDURES:

A. Purpose: Special skills are those skills, procedures, and medications that are requested by an EMS service to enhance emergency treatment capabilities beyond the normal scope of practice, as defined in the Emergency Medical Services Act. Applications are reviewed and approved or disapproved by the medical direction committee, and once approved, become a legally recognized addition to the service capabilities.

B. General: All levels of EMS personnel, including licensed EMS first responders and all levels of licensed EMTs are eligible for special skills consideration for any procedure, skill or medication.

C. Application procedure: The EMS service medical director, or his designee, shall coordinate with the EMS service director, and shall apply for special skills to the EMS medical direction committee.

D. Application process: The completed application shall be submitted via the EMS licensing management system portal no later than 30 days prior to the medical direction committee meeting. While the degree of detail in each section may vary to match the nature of the skill requested, all applications should include the following elements, in order:

(1) application cover page: titled to state the requested special skill, date of application, name of service, service director name and medical director name;

(2) contact information page: must include address and contact information for the service, service director and medical director;

(3) letters of support: must include individual letters of support from the service director and medical director; additional letters of support from the local medical community or evidence of notification of the local medical community may be required; the need for letters of notification and support from the local medical community and who provides the letters must be adjusted to match the nature of the special skill requested;

(4) service description: provide a concise description of the EMS service; this includes such items as basic call demographics relevant to the applicant, level of licensure of providers and names and locations of the primary receiving medical facilities;

(5) description of the special skill: provide a description of the procedure, medication or requested skill; include information on risks, benefits, indications and contraindications;

(6) justification and statement of need: provide a statement explaining why the special skill is needed; this should include a description of the current medical intervention or alternative practice to the special skill and a risk or benefit analysis that supports the special skill requested; the estimated number of potential interventions per year, other relevant statistical data and a statement indicating the level of current scientific information/studies to support the requested special skill; the level of scientific justification can be adjusted to match the level of the special skill requested;

(7) protocol: provide a copy of the treatment protocol; include other operational protocols relevant to the special skill, if applicable;

(8) training: provide a training syllabus; this must include learning objectives and the training hours for initial and continuing education; this section should also include a description of the instructors, how training will be completed, and a description of the method used to initially evaluate the skill; once initial training is completed, a list of trained and approved personnel shall be provided to the medical direction committee; these special skill authorized licensed EMS personnel must appear on the service's personnel list on the *New Mexico EMS tracking and reporting system database*.

(9) QA/QI program: provide a description of the QA/QI process for the special skill,

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including frequency of evaluation, names and qualifications of the personnel involved in the process; include a copy of the evaluation tool or forms that will be used, if applicable; and

(10) the application and all supporting documentation shall be submitted to the EMS bureau;
attn: EMS program manager.

E. Upon receipt, the state EMS medical director and state EMS program manager will review the application. The service will be notified if the application is found to be incomplete or to contain significant errors.

F. Applications must be received at the bureau at least 30 days prior to the next regularly scheduled medical direction committee meeting to be placed on the agenda of that meeting for consideration by the medical direction committee.

G. The medical direction committee shall take action on all special skills applications on the agenda at their regularly scheduled meeting. The medical direction committee may take the following actions on the application: approved with limitations or restrictions, denied or tabled with a request for a formal presentation or additional information by the requesting service medical director or their designee.

H. The medical direction committee may give an approval subject to specific conditions, limitations or restrictions. This may include a written and practical examination.

I. Within 10 working days following the decision of the medical direction committee, the state EMS program manager shall provide a written or email response to the applicant regarding the action of the medical direction committee.

J. Special skills may not be utilized until receipt of the special skill approval letter from the bureau any specific conditions or limitations will be evidenced in the approval letter from the bureau.

K. **Monitoring:** It is expected that EMS services with approved special skills will continuously comply with the requirements of their application and approval letter. This includes, but is not limited to, such items as training curricula, approved instructors, quality assurance, protocols and data collection. Any changes to the approved application shall be sent to the state EMS program manager for concurrence/coordination with the medical direction committee.

L. The medical direction committee may immediately suspend or revoke special skill privileges for an individual or service that loses medical direction, or fails to comply with the stated requirements, or for any other reason to protect the health and welfare of the people of New Mexico.

M. If a new medical director assumes control of a service with an active special skill program, the bureau shall receive a letter of support from the new medical director within 30 days or the special skill approval may be withdrawn.

N. The service shall maintain a current list of all providers trained and approved to utilize the special skill. This list must be provided to the bureau upon request.

O. **Reporting:** During the first year, a semi-annual (six month) report shall be submitted for review by the medical direction committee; subsequent reports shall be due one year from date of initial approval, and annually on the approval anniversary date thereafter. The EMS bureau or medical direction committee may request a report at any time. The medical direction committee may excuse an agency from the yearly report based on adequate surveillance being available from the state patient care report database. If the medical direction committee determines a special skill program will not be renewed, the state EMS program manager shall provide a written notification to the service director and the service medical director within 10 working days. The special skills program will be placed on the agenda of the next, or subsequent, regularly scheduled meeting of the medical direction committee and final determination regarding renewal will be made.

P. **Report document:** The report to the medical direction committee should focus particular attention on special skill utilization and patient outcomes after this utilization; patient identifiers shall not be included; all adverse outcomes, protocol deviations, dosing errors, or quality assurance issues related to the special skill must be reported. The written special skill report shall include the following minimum elements:

- (1) report cover page: titled to state the special skill reported, date, name of service, service director and medical director;
- (2) contact information page: shall include address and contact information for the service, service director and medical director;
- (3) letters of support: must include individual letters of continued support from the service director and service medical director;
- (4) statistics and outcome data: provide data on the utilization and patient outcomes involving the special skill; do not include patient identifiers; all adverse outcomes related to the special skill must be reported;
- (5) continuing education: provide evidence of the continuing education program and

refresher program;

(6) personnel list: provide a list of all personnel authorized to perform the special skill; present special skill authorized licensed EMS personnel must appear on the service's personnel list required for the New Mexico EMS tracking and reporting system database;

(7) QA/QI program: provide evidence of the ongoing QA/QI program; and

(8) renewal: during a regularly scheduled meeting, the medical direction committee shall review all ongoing individual special skills programs on their three-year anniversary and make a determination on renewal.

Q. Special skills programs will remain active until a final determination regarding renewal has been made.

R. **Special skills application:** Special skills applications shall include, but need not be limited to, the following content:

- (1) general section;
- (2) EMS service name;
- (3) address;
- (4) service chief/director;
- (5) contact phone number;
- (6) physician medical director;
- (7) physician/medical director contact phone number;
- (8) special skill proposed;
- (9) level of licensure necessary for special skill(s);
- (10) estimated number of personnel to be trained;
- (11) estimated date of initial training;
- (12) training/quality assurance;
- (13) curriculum description, including learning objectives, training hours, etc.;
- (14) lead instructor and brief summary of their qualifications, or resume;
- (15) resumes of any new instructors;
- (16) letter of commitment from supporting institution, if training/experience is required;
- (17) proposed continuing education plan;
- (18) attach a description of quality assurance plan, including periodic case reviews and

ongoing problems;

- (19) identification and steps for remedial action if necessary; and
- (20) signature and acknowledgement of person completing the application.

[7.27.11.10 NMAC - Rp, 7.27.11.10 NMAC,9/9/2025]

7.27.11.11 EMS PERSONNEL JOB DESCRIPTIONS:

A. **Introduction:** The bureau is providing the following general position description for the New Mexico EMS provider positions for first responder, EMT-basic, EMT-intermediate, and EMT-paramedic. It is the ultimate responsibility of an employer to define specific job descriptions within each EMS service.

B. **Qualifications:**

- (1) successfully complete a recognized training course from an approved EMS training institution;
- (2) possess a valid course completion certificate, and accomplish all state licensure examination application requirements;
- (3) additionally, applicants shall meet all established requirements for initial licensing as identified by the current EMS licensure regulations;
- (4) a copy of these regulations is available through the EMS bureau;
- (5) generally, the knowledge and skills required demonstrate the need for a high school education or equivalent;
- (6) ability to communicate verbally; via telephone and radio equipment;
- (7) ability to lift, carry, and balance up to 125 pounds (250 pounds with assistance);
- (8) ability to interpret written, oral, and diagnostic form instructions;
- (9) ability to use good judgment and to remain calm in high-stress situations;
- (10) ability to work effectively in an environment with loud noises and flashing lights;
- (11) ability to function efficiently throughout an entire work shift;
- (12) ability to calculate weight and volume ratios and read small English print, both under life

threatening time constraints;

- (13) ability to read and understand English language manuals and road maps;
- (14) accurately discern street signs and address numbers;
- (15) ability to interview patient, family members, and bystanders;
- (16) ability to document, in writing, all relevant information in a prescribed format;
- (17) ability to converse orally and in written form in English with coworkers and hospital staff

as to status of patient;

- (18) good manual dexterity, with ability to perform all tasks related to the highest quality of

patient care;

(19) ability to assume a variety of postural positions to carry out emergency and non-emergency patient care, including light extrication; from crawling, kneeling, squatting, twisting, turning, bending, to climbing stairs and ladders, and the ability to withstand varied environmental conditions such as extreme heat, cold, and moisture; and

- (20) ability to work in low light, confined spaces and other dangerous environments.

C. Competency areas:

(1) **Licensed EMS first responder:** Must demonstrate competency handling emergencies utilizing all basic life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of first responder, to include the ability to demonstrate competency for all skills and procedures currently approved for the first responder, as identified by the current scope of practice document.

(2) **Emergency medical technician-basic:** Must demonstrate competency handling emergencies utilizing all basic life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of EMT-basic, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-basic, as identified by the current scope of practice document.

(3) **Emergency medical technician-intermediate:** Must demonstrate competency handling emergencies utilizing all basic life support and intermediate life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of EMT-intermediate, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-intermediate, as identified by the current scope of practice document.

(4) **Emergency medical technician-paramedic:** Must demonstrate competency handling emergencies utilizing all basic life support and advanced life support equipment and skills in accordance with all behavioral objectives of an approved New Mexico curriculum of EMT-paramedic, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-paramedic, as identified by the current scope of practice document.

D. Description of tasks for all EMS levels:

(1) Receives call from dispatcher, responds verbally to emergency calls, reads maps, may drive emergency vehicle to emergency site, uses most expeditious route, and observes traffic ordinances and regulations.

(2) May use equipment and other devices and procedures as authorized by level of licensure and scope of practice.

(3) Assists in lifting, carrying, and transporting patient to an ambulance and to a medical facility.

(4) Reassures patients and bystanders and searches for medical identification emblem to aid in care.

(5) Extricates patient from entrapment, assesses extent of injury, uses prescribed techniques and appliances, radio dispatcher for additional assistance or services, provides light rescue service if required and trained, provides additional emergency care following service established protocols.

(6) Complies with regulations in handling deceased, notifies authorities, arranges for protection of property and evidence at scene.

(7) Determines appropriate facility to which patient will be transported, report nature and extent of injuries or illness to the facility, asks for direction from hospital physician or emergency department staff.

(8) Observes patient in route and administers care as directed by physician or service-established protocols.

(9) Identifies diagnostic signs that require communication with facility.

(10) Assists in removing patient(s) from ambulance and into emergency facility.

(11) Reports verbally, and in writing, observations about and care of patient at the scene, en-route to facility, and to the receiving facility. Written reports shall be completed for all patient interactions, which

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include any visual, verbal, or physical patient contact, by the most appropriate EMS caregiver, whether or not the patient was transported to a facility, including patient refusals.

(12) Provides assistance to emergency department staff as required.

(13) Replaces supplies, sends used supplies for sterilization, checks all equipment for future readiness, maintains ambulance in operable condition, ensures ambulance cleanliness and orderliness of equipment and supplies, decontaminates vehicle interior, determines vehicle readiness by checking oil, gas, water in battery and radiator, and tire pressure, maintains familiarity with all specialized equipment.

[7.27.11.11 NMAC - Rp, 7.27.11.11 NMAC, 9/9/2025]

HISTORY OF 7.27.11 NMAC: [RESERVED]

History of Repealed Material:

7.27.11 NMAC, Supplemental Licensing Provisions (filed 12/17/2012) Repealed 8/15/14.

7.27.11 NMAC, Emergency Medical Services - Supplemental Licensing Provisions filed 7/28/2014 - repealed effective 12/12/2017.

7.27.11 NMAC, Emergency Medical Services - Supplemental Licensing Provisions (filed 11/30/2017) - repealed effective 9/9/2025.

Other History:

7.27.11 NMAC, Emergency Medical Services - Supplemental Licensing Provisions (filed 7/28/2014) was replaced by 7.27.11 NMAC, Emergency Medical Services - Supplemental Licensing Provisions, effective 12/12/2017.

7.27.11 NMAC, Emergency Medical Services - Supplemental Licensing Provisions (filed 11/30/2017) was replaced by 7.27.11 NMAC, Emergency Medical Services - Supplemental Licensing Provisions, effective 9/9/2025.