

This is an amendment to 11.4.1 NMAC, Section 7, effective 11/7/2025

11.4.1.7 DEFINITIONS: The definitions adopted below shall apply to all WCA rules unless expressly indicated otherwise in a specific part of these rules.

A. “Act” means collectively: the Workers’ Compensation Act, the Workers’ Compensation Administration Act, and the Occupational Disease Disablement Law, Sections 52-4-1 to 52-4-5 NMSA 1978. This definition includes prior law applicable to the particular facts of the claim.

B. “Administration” means the workers’ compensation administration (WCA).

C. “Bad faith” means conduct in the handling of a claim by any person that amounts to fraud, malice, oppression or willful, wanton or reckless disregard of the rights of any party.

D. “Cause” means any and all proceedings before the WCA pertaining to the same disease or accidental injury and assigned the same file number by the clerk of the administrative court.

E. “Claim” means any allegation of entitlement to benefits or relief under the act, which has been communicated to the employer by the giving of notice as required by the act.

F. “Claims administrator” means the insurance carrier, third party administrator, self-insured association, self-insured employer, or any claims coordinator, if any, designated by the employer or another claims payer to provide claims processing services on workers’ compensation claims.

G. “Clerk” (also referred to as clerk of the administrative court or clerk of the WCA) means any individual assigned by the director to oversee the filing of claims and records with the WCA.

[G] H. “Complaint” means a written request for workers’ compensation benefits or any relief under the Act, filed on a mandatory form with the clerk of the WCA by a worker, employer, insurance carrier or the uninsured employers’ fund.

[H] I. “Director” means the director of the WCA.

[I] J. “Employer” means, collectively, unless otherwise stated: an employer subject to the act; a self-insured entity, group or pool; a workers’ compensation insurance carrier or its representative; or any authorized agent of an employer or insurance carrier, including any individual owner, chief executive officer or proprietor of any entity employing workers.

[J] K. “Health care provider” (also referred to in the rules as “HCP”) means any person, entity or facility authorized to furnish health care to an injured worker pursuant to Section 52-4-1 NMSA 1978, including any provider designated pursuant to Sections 52-1-49 or -51 NMSA 1978 and may include a provider licensed in another state if approved by the director, as required by the act.

[K] L. “IME”, or independent medical examination, means a medical examination of a worker, by a provider other than a previously designated health care provider, upon whom the parties have agreed or the judge has appointed according to the act.

[L] M. “Judge” means a workers’ compensation judge appointed by the director pursuant to Section 52-5-2 NMSA 1978.

[M] N. “Mediation conference” means a mandatory conference at which all parties named in the complaint shall appear and present their positions to the mediator.

[N] O. “Mediator” means a director’s designee, who will evaluate and attempt to resolve a complaint by holding a mediation conference and issuing a recommendation for resolution of the complaint.

[O] P. “Medical records” means:

- (1) all records, reports, letters, and bills produced or prepared by a HCP relating to the care and treatment rendered the worker;
- (2) all other documents generally kept by the HCP in the normal course of business relating to the worker, including, but not limited to, clinical, nurses’ and intake notes, notes evidencing the patient’s history of injury, subjective and objective complaints, diagnosis, prognosis and/or restrictions, reports of diagnostic testing, hospital records, logs and bills, physical therapy records and bills for services rendered.

[P] Q. “Party” may include any of the following:

- (1) an employer against whom a claim has been asserted by an injured or disabled worker;
- (2) an injured or disabled worker asserting a claim against an employer;
- (3) the uninsured employers’ fund, if a claim has been asserted against it;
- (4) a health care provider named in a billing dispute or seeking qualification as an out-of-state provider; or

(5) any other person or entity named in an administrative enforcement proceeding.

[Q] **R. “Pending cause”** means any cause in which a party has filed a document with the clerk of the WCA within the previous six months, and which has not yet been administratively closed by the clerk.

[R] **S. “Person”** means any individual, association, organization, reciprocal or Lloyd’s plan insurer, partnership, firm, syndicate, trust, corporation and every legal entity as defined in Section 59A-1-10 NMSA 1978.

[S] **T. “Pleading”** means any document filed and endorsed by the clerk.

[F] **U. “Rules of civil procedure”** means the Rules of Civil Procedure for the district courts, as adopted by the supreme court of New Mexico.

[U] **V. “Rules of evidence”** means the Rules of Evidence as adopted by the supreme court of New Mexico.

[W] **W. “Rules of the WCA”** means rules enacted by the WCA and cited as 11.4 NMAC.

(1) These rules are organized by title, chapter, part, section, paragraph and subparagraph.

(2) For ease of use, these rules may be referred to in writing and speech by part, section, paragraph and subparagraph.

[W] **X. “Unfair claims processing”** means any practice, whether intentional or not, which unreasonably delays or prolongs the payment of benefits at a rate not consistent with the act. “Unfair claims processing” is a less severe violation than “bad faith” and includes, but is not limited to, any and all of the following practices with respect to claims, by an employer, insurer, third party administrator, worker or other person:

(1) knowingly misrepresenting pertinent facts relating to workers’ compensation benefits or failing to disclose facts material to a workers’ compensation claim;

(2) failing to acknowledge and act promptly upon communications with respect to claims;

(3) failing to adopt and implement reasonable standards for the prompt investigation and processing of claims;

(4) failing to affirm or deny coverage of claims within a reasonable time after a request for payment of benefits has been submitted to an employer;

(5) not attempting in good faith to develop prompt, fair and equitable settlements of claims in which liability has become clear;

(6) compelling litigation to recover amounts due by offering substantially less than the amounts ultimately recovered in actions brought by similarly situated workers;

(7) initiating litigation when benefits are currently being paid at the maximum rate of entitlement under the act;

(8) soliciting, accepting or obtaining a complete release of liability in exchange for an acceleration of benefits, or discounting an acceleration of benefits, where such an acceleration is not made pursuant to a lump sum payment approved by a judge; and

(9) failing to timely pay authorized and undisputed medical bills.

[X] **Y. “Wage records”** means all records evidencing all wages, commissions, overtime pay, gratuities, meals, board, rent, housing or lodging received from any employer during all time periods relevant to the act.

[Y] **Z. “Worker”** means an injured or disabled employee.

[11.4.1.7 NMAC - Rp, 11 NMAC 4.1.7, 10/1/2014; A, 1/1/2023; A, 11/7/2025]